**ASAN Medical Center**
88, Olympic-ro 43-gil, Songpa-gu, Seoul 05505, Korea
http://eng.amc.seoul.kr

# Immunization Form (Mandatory)

He/She will begin clinical fellowship program at Asan Medical Center in Seoul, Korea.
In order to maintain a safe environment for our employees and for our patients, the following information is needed prior to his/her placement under the infection control guidelines.
Please complete this form in order to facilitate the administrative process.

| **Full Legal Name** | | |
|---|---|---|
| Last Name | First Name | Middle Name |
| | | |

| **Nationality** | **Date of Birth (Month/Day/Year)** | **Gender** |
|---|---|---|
| | | ❑Male ❑Female |

**Required immunizations: Please record the date of immunizations or blood tests. Please print clearly.**

## A. Measles–Mumps–Rubella (MMR)

: Proof of positive IgG titer **OR** Two doses of each individual component.

Positive IgG Titers :

Measles: _____ /_____ /_____ (Month Day Year)

Mumps: _____ /_____ /_____ (Month Day Year)

**OR**

Measles Vaccination:

#1: _____ /_____ /_____ (Month Day Year)

#2: _____ /_____ /_____ (Month Day Year)

Mumps Vaccination:

#1: _____ /_____ /_____ (Month Day Year)

#2: _____ /_____ /_____ (Month Day Year)

## B. Tetanus-Diphtheria-Pertussis (Tdap)

: Only the Tdap vaccine (which contains the pertussis component) is acceptable. Other forms of tetanus-containing vaccines, such as Td, are not permitted. **(within 10 years)**

Tdap Vaccination: _____ /_____ /_____ (Month Day Year)

## C. Varicella (Chickenpox)

: Proof of positive IgG titer **OR** Two doses required.

Varicella Positive IgG Titer: _____ /_____ /_____ (Month Day Year)

**OR**

Varicella Vaccination #1: _____ /_____ /_____ (Month Day Year)

Varicella Vaccination #2: _____ /_____ /_____ (Month Day Year)
4-8 weeks apart from #1

## D. Active tuberculosis (CXR)

: Chest X-ray **within 6 months** from the date of visit to Asan Medical Center.

Chest X-ray: _____ /_____ /_____ (Month Day Year)

Result : The imaging shows no lesions indicative of active pulmonary tuberculosis. (Normal) ❑ Yes ❑ No

**E. Latent TB Infection (TST or IGRA)**

: The results of Tuberculin Skin Test (TST) **OR** IGRA test required **(either within 1 year)**.

TST Date: _____ /_____ /_____ Result : ❑ Positive ❑ Negative

Month Day Year

**OR**

※ If positive, treatment is recommended.

IGRA Date: _____ /_____ /_____ Result : ❑ Positive ❑ Negative

Month Day Year

**F. Hepatitis B**

: Proof of positive IgG titer **OR** Three doses required.

Hepatitis B Positive IgG Titer: _____ /_____ /_____

Month Day Year

**OR**

Hepatitis B Vaccination #1:

_____ /_____ /_____

Month Day Year

Hepatitis B Vaccination #2:

at least 1 month* after #1

_____ /_____ /_____

Month Day Year

Hepatitis B Vaccination #3:

at least 2 months* after #2

at least 4 months* after #1

_____ /_____ /_____

Month Day Year

**G. Influenza**

: If the visit is during **November ~ April**, latest vaccination must be done at least **2 weeks** prior to arrival date.

Influenza Vaccination Date: _____ /_____ /_____

Month Day Year

## Overall Comments

1) Does he/she have communicable disease(s)?

❑ Yes ❑ No

2) Did he/she have any close contact with an infectious disease patient within the last 3 weeks?

❑ Yes ❑ No

I hereby certify that the above information is true and correct.

| Official Office Stamp | Signature of Physician | Date |
|---|---|---|