



To: Incoming Visiting Student

RE: Health Requirements for Visiting Student at Eastern Virginia Medical School

Eastern Virginia Medical School (EVMS) adheres to the Centers for Disease Control (CDC) guidelines regarding immunization of health-care workers. You must provide copies of immunization documentation (i.e. shot records), laboratory reports indicating immunity, and documentation of placement and results of tuberculin skin tests or chest x-ray reports if previously tuberculin skin test positive.

*Copies of immunization records, laboratory reports, and radiology report **MUST** be included with this form. If you do not have immunization records, you must have antibody titers drawn to prove immunity to measles, mumps, rubella and varicella and provide EVMS with copies of lab reports.*

Visiting students are responsible for the cost of immunizations, laboratory tests, tuberculin skin tests, and/or chest x-rays as these are pre-matriculation requirements.

Name: \_\_\_\_\_ M/F (Circle One)

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number: \_\_\_\_/\_\_\_\_/\_\_\_\_

Home Phone Number: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Cell Number: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

E-Mail Address: \_\_\_\_\_

Dates of Rotation at EVMS: \_\_\_\_/\_\_\_\_/\_\_\_\_ TO \_\_\_\_/\_\_\_\_/\_\_\_\_

**The following are pre-matriculation requirements:**

1. Tuberculin skin testing: you are required to provide documentation of a two-step tuberculin skin test within (4) four months prior to the program start date. If the first-step TST is negative, the second-step TST should be administered 1-3 weeks after the first TST was read. (If you have had a TST within the past twelve months, this may be used as the first-step TST. PPD#1; \_\_\_\_/\_\_\_\_/\_\_\_\_ Result; \_\_\_\_\_ PPD #2; \_\_\_\_/\_\_\_\_/\_\_\_\_ Result; \_\_\_\_\_)
2. If you have had a **previous positive** PPD, attach a copy of a chest x-ray report done within the past year **AND** physician documentation regarding treatment dates with antibiotic therapy or why treatment was contraindicated. Please contact us to receive a TB Symptom and Surveillance form that must also be completed. Date of positive PPD; \_\_\_\_/\_\_\_\_/\_\_\_\_. Date of CXR; \_\_\_\_/\_\_\_\_/\_\_\_\_, Result of CXR; \_\_\_\_\_  
Date of treatment; \_\_\_\_/\_\_\_\_/\_\_\_\_, Length of Treatment; \_\_\_\_\_
3. Measles, Mumps, Rubella (MMR) immunity: attach documentation of two doses of live MMR vaccine if you were born in or after 1957 or copies of measles, mumps, and rubella IgG antibody titers indicating immunity. MMR#1; \_\_\_\_/\_\_\_\_/\_\_\_\_



- MMR#2; \_\_\_\_/\_\_\_\_/\_\_\_\_ **OR** Dates & Results of Measles Mumps Rubella Titers;  
\_\_\_\_/\_\_\_\_/\_\_\_\_, \_\_\_\_\_
4. Varicella immunity: attach a copy of a varicella IgG antibody titer indicating immunity or documentation of two doses of Varicella vaccine. Varicella Vaccine #1; \_\_\_\_/\_\_\_\_/\_\_\_\_ Varicella Vaccine #2; \_\_\_\_/\_\_\_\_/\_\_\_\_ **OR** Date and Results of Varicella Titer; \_\_\_\_/\_\_\_\_/\_\_\_\_, \_\_\_\_\_
  5. Diphtheria/Pertussis/Tetanus (DPT): attach series of five immunizations during childhood. If this documentation is not available, the requirement will be waived as vaccination of adults is not recommended.
  6. Tetanus/Diphtheria/Pertussis (Tdap): attach documentation of a **Tdap** immunization. If it has been less than two years since your last Td booster, attach a copy of the Td booster documentation. **(Tdap and Td are not the same immunization.)** Tdap Date: \_\_\_\_/\_\_\_\_/\_\_\_\_
  7. Polio: attach documentation of polio immunization (OPV or IPV) series of 4 during childhood. If this documentation is not available, the requirement will be waived as vaccination of adults is not recommended.
  8. Hepatitis B: If you have had the Hepatitis B vaccine series, attach documentation of the dates of the three doses and a Hepatitis B surface antibody result indicating immunity. HepB#1; \_\_\_\_/\_\_\_\_/\_\_\_\_, Hep B #2; \_\_\_\_/\_\_\_\_/\_\_\_\_, Hep B #3; \_\_\_\_/\_\_\_\_/\_\_\_\_ and Date and Result Hep B Surface Antibody Titer; \_\_\_\_/\_\_\_\_/\_\_\_\_, \_\_\_\_\_

If, you have any questions regarding these mandatory requirement please call Lisa Lee at (757) 446-5870. Forms can be e-mailed to [leelw@evms.edu](mailto:leelw@evms.edu) or faxed to (757) 446-7188.