

Dear Colleague,

Welcome to Trinity Health Mid-Atlantic. The Employee Health/WorkCare team is looking forward to meeting you when you arrive for your pre-placement physical. To speed up your on-boarding process, please have a healthcare provider complete the immunization information below. This form may be completed/signed off by your primary care provider and/or you may bring an immunization summary from your former employer, school, or other agency which includes the immunization information.

Colleague Name: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_

<b>Hep B</b>	<b>Titer</b> Date ___/___/___ <input type="checkbox"/> Immune <input type="checkbox"/> Non-Immune <b>Vaccinated Dates</b> 1: ___/___/___ 2:___/___/___ 3:___/___/___
<b>Rubella (German Measles)</b>	<b>Titer</b> Date ___/___/___ <input type="checkbox"/> Immune <input type="checkbox"/> Non-Immune <b>Vaccinated Dates</b> 1: ___/___/___ 2:___/___/___
<b>Rubeola (Measles)</b>	<b>Titer</b> Date ___/___/___ <input type="checkbox"/> Immune <input type="checkbox"/> Non-Immune <b>Vaccinated Dates</b> 1: ___/___/___ 2:___/___/___
<b>Mumps</b>	<b>Titer</b> Date ___/___/___ <input type="checkbox"/> Immune <input type="checkbox"/> Non-Immune <b>Vaccinated Dates</b> 1: ___/___/___ 2:___/___/___
<b>Varicella (Chicken Pox)</b>	<b>Titer</b> Date ___/___/___ <input type="checkbox"/> Immune <input type="checkbox"/> Non-Immune <b>Vaccinated Dates</b> 1: ___/___/___ 2:___/___/___
<b>Tdap (Tetanus, Diphtheria, pertussis)</b>	<b>Vaccinated Date</b> ___/___/___
<b>Influenza</b>	<b>Vaccinated Date</b> ___/___/___
<b>COVID Vaccine</b>	<b>Manufacturer:</b> _____ <b>Vaccinated Dates</b> 1: ___/___/___ 2:___/___/___

Provider Name (Printed): \_\_\_\_\_

Provider Name (Signature) \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

