COLLEGE
OF DENTISTRY
UIC

Immunization Requirements

Incoming Clinical Providers,

Dentistry is a health care profession which has the potential to expose the practitioner to infectious diseases. Immunizations substantially reduce both the providers' susceptibility to these diseases as well as the potential for disease transmission to other dental health care providers and patients. Thus, immunizations are an essential part of the prevention and infection-control programs at the College of Dentistry.

The College of Dentistry requires that all clinical healthcare providers provide:

1. Proof of immunization by a blood titer to: Rubeola (Measles), Mumps, Rubella (German Measles), Varicella Zoster (Chicken Pox), and Hepatitis B.
2. Dates of immunization to Tetanus and Diphtheria
3. Tuberculosis testing from within the previous 12 months.

Students are required to show immunization against Polio. All other College of Dentistry healthcare providers are exempt from this requirement.

Steps to follow:

- All incoming students (including pre-dental, IDDP, and post-graduate) must have the attached form filled out by a licensed health care provider. The completed form must be turned in to the Office of Clinical Affairs. You will be provided 7 months grace period to complete the Hepatitis B immunization series and receive a titer.
- Employees and prospective employees of the UIC College of Dentistry shall be seen at the UIC University Health Service. Before your appointment at University Health Service you may have the attached form completed by your own provider so as to avoid duplicating recent tests.
- Temporary service employees are employees of the agency and not of the College of Dentistry. It is the responsibility of the agency to ensure that their employees show compliance with all the immunization requirements found in this document. The agency must be able to provide proof of immunization to the College upon request.
- Non-Salaried, Adjunct Faculty and Volunteer Faculty shall be seen at their own provider. The attached form must be filled out by a licensed health care provider.

Failure to abide by the mandatory requirements outlined in the College *Immunization Policy* will preclude an individual from participating in patient care at the College of Dentistry. Please direct any questions to the Office of Clinical Affairs, 312-996-3544.

COLLEGE OF DENTISTRY
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Clinical Administration
801 S. Paulina Room 301
Chicago, IL 60612
312-996-3544

MANDATORY MEDICAL IMMUNIZATION DOCUMENTATION FORM

NOTE: This is the only form accepted by the UIC College of Dentistry

PART I: To be completed by the Student/Employee (Please Print)

_____ _____ ____/____/____
Last Name *First* *Middle Initial* *UIN (If assigned)* *Date of Birth*

_____ _____ _____
Address (Number and Street) *City and State* *Zip Code*

(_____)_____ _ M_ _ _F _____
Home Telephone Number Sex *E-mail Address* Year of Admission

I authorize the University of Illinois at Chicago to release this immunization record to the Illinois Department of Public Health, or its designated representative, for compliance audits and in the event of a health or safety emergency.

Student/Employee Signature_____ Date_____

PART II: To be completed and signed by a healthcare provider. All dates must include month, day, and year. All required titer results must be enclosed with this form. (Check appropriate box.)

MEASLES (RUBEOLA) * *Attach copy of laboratory report*
□ Immunization Confirmed with blood titer
Date of titer::_____/_____/_____Result:_____
□ Date of re-immunization::_____/_____/_____

RUBELLA (GERMAN MEASLES)* *Attach copy of lab report*
□ Immunization Confirmed with blood titer
Date of titer::_____/_____/_____Result:_____
□ Date of re-immunization::_____/_____/_____

MUMPS * *Attach copy of laboratory report*
□ Immunization Confirmed with blood titer
Date of titer::_____/_____/_____Result:_____
□ Date of re-immunization::_____/_____/_____

TETANUS & DIPHTHERIA (TD, DT or DPT)
**Tetanus Toxoid (TT) is NOT acceptable*
Three immunizations are needed OR date of last booster OR date of adult immunization:
□ Immunization 1 Date _____/_____/_____
□ Immunization 2 Date _____/_____/_____
□ Immunization 3 Date _____/_____/_____
OR
□ Last Booster Date::_____/_____/_____
OR
□ Immunization as an adult Date:_____/_____/_____

POLIO
*(Polio Immunization is NOT required for College of Dentistry Healthcare Providers but **IT IS A REQUIREMENT FOR STUDENTS**)*
At least three doses of inactivated polio vaccine (IPV), live oral poliovirus vaccine (OPV), or four doses of any combination of IPV/OPV.
□ Primary Series Completed:
Immunization 1 Date: ____/____/_____ □ Oral □ Injection
Immunization 2 Date:_____/____/_____ □ Oral □ Injection
Immunization 3 Date:____/____/_____ □ Oral □ Injection
Last Booster Date: _____/_____/_____ □ Oral □ Injection
□ Immunization as an adult Date:_____/_____/_____
OR
□ Immunization confirmed by **titer** Date:____/_____/_____

TUBERCULOSIS
□ Has had the disease □ Has not had the disease
NOTE: Only 2 Step tuberculin skin test (TST) or Quantiferon Gold blood test accepted for initial registration with UIC-COD.
□ TST Step 1 date read ____/____/_____ Results _____mm induration
□ TST Step 2 date read ____/____/_____ Results _____mm induration
OR
□ Quantiferon Gold date _____/_____/_____ Results _____
If positive test result then a baseline Chest x-ray is required:
□ Date of x-ray:_____/_____/_____ □ Positive □ Negative
□ Had BCG vaccine. Date :_____/_____/_____
NOTE: History of BCG vaccine does not exempt from TB Testing.

HEPATITIS B * *Attach copy of laboratory report*
Three immunizations are needed and proof of immunity by titer.
□ Immunization 1 Date _____/_____/_____
□ Immunization 2 Date _____/_____/_____
□ Immunization 3 Date _____/_____/_____
AND
□ Immunization confirmed by titer date:_____/_____/_____
HB surface antigen □ Positive □ Negative
HB surface antibody □ Positive □ Negative
Antibody must be positive or immunization is required

MEDICAL EXEMPTIONS
□ Attach physician's statement of medical contraindications with duration of medical condition.

CERTIFICATION BY HEALTH CARE PROFESSIONAL
_____Circle: RN MD DO Other_____
Name of Health Care Provider completing form

Name and address of Institution or Clinic (or stamp)

Phone (_____)_____ Fax (_____)_____

VARICELLA ZOSTER (CHICKEN POX) **Attach copy of lab report*

□ Immunization Confirmed with blood titer

Date of titer:_____/_____/_____Result:_____

□ Date of re-immunization:_____/_____/_____

I certify that this information is complete and correct to the best of my knowledge.

Signature_____ Date:_____/_____/_____

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