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.
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)

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First</th>
<th>Middle Initial</th>
<th>UIN (If assigned)</th>
<th>Date of Birth</th>
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<tr>
<th>Address (Number and Street)</th>
<th>City and State</th>
<th>Zip Code</th>
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<thead>
<tr>
<th>Home Telephone Number</th>
<th>Sex</th>
<th>E-mail Address</th>
<th>Year of Admission</th>
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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:__/__/____
- Last Booster Date:__/__/____
- 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:__/__/____
- Immunization confirmed by titer Date:__/__/____

### TUBERCULOSIS
- Has had the disease □ Has not had the disease □
- Date:__/__/____
- TST Step 1 date read:__/__/____ Results mm induration
- TST Step 2 date read:__/__/____ Results mm induration
- Quantiferon Gold date:__/__/____ Result:_________________
- If positive test result then a baseline Chest x-ray is required:
  - Date of x-ray:__/__/____ Results:_________________
- History of BCG vaccine does not apply
- Date:__/__/____

### 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:__/__/____

### 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 (_____)________________

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

Signature _____________________________ Date:__/__/____