



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, Advance Standing, and post-graduate) must have the attached form filled out by a licensed health care provider. The completed form must be uploaded into CastleBranch along with lab titer reports. 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 must 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

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

Form fields for personal information: Last Name, First, Middle Initial, UIN (If assigned), Date of Birth, Address (Number and Street), City and State, Zip Code, 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.

Signature _____

PART II: To be completed and signed by a healthcare provider. All dates must include month, day, and year. All required titer results

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: ___/___/___

VARICELLA ZOSTER (CHICKEN POX) *Attach copy of lab report
Immunization Confirmed with blood titer
Date of titer: ___/___/___ Result: _____
Date of re-immunization: ___/___/___

TUBERCULOSIS
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.

FLU VACCINE 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 ___/___/___
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 (___) _____
I certify that this information is complete and correct to the best of my knowledge.
Signature _____ Date: ___/___/___