

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 complete	d by the Student/E	Employee (Please Prin	nt)		1	
					Date of Birth	<i>,</i>
Last Name	First	Middle Initial	UIN (If assigned)			
Address (Number and Stre	et)		City and State	Zip Code		
()		M F				
Home Telephone Number		Sex	E-mail Address		Year of Admi	ission
I authorize the Universi	ity of Illinois at Ch	icago to release this	immunization record to the Illinois De	partment of Pub	lic Health, or its desig	gnated
representative, for com	pliance audits and	in the event of a hea	Ith or safety emergency.			
Signature						
			All dates must include month, day, and		al Maria and a sales	
PART II: 10 be complete	ed and signed by a	neaithcare provider.	All dates must include month, day, and	ı year. Ali require	ed titer results	
MEASLES (RUBEOLA) *	Attach copy of lab	oratory report	TUBERCULOSIS			
☐ Immunization Confirmed	with blood titer		☐ Quantiferon Gold date/_	/ Results	S	
Date of titer::/	/ Result:		If positive test result then a base	line Chest x-ray is r	equired:	
☐ Date of re-immunization::		/	□ Date of x-ray:/	_/ □ Posit	ve □ Negative	
RUBELLA (GERMAN ME	ASLES)* Attach co	py of lab report	☐ Had BCG vaccine. Date :			
☐ Immunization Confirmed	with blood titer		NOTE: History of BCG vaccine do	es not exempt fron	n TB Testing.	
Date of titer::/	/ Result:					
☐ Date of re-immunization::		/	FLU VACCINE date/	/		
MUMPS * Attach copy of	of laboratory repor	t				
☐ Immunization Confirmed	with blood titer		HEPATITIS B * Attach copy of I	aboratory report		
Date of titer::/	/ Result:		Three immunizations are needed and		•	
☐ Date of re-immunization::			☐ Immunization 1 Date/_		_	
		·	☐ Immunization 2 Date/_			
TETANUS & DIPHTHERI	•		AND		_	
*Tetanus Toxoid (TT) is NOT Three immunizations are ne	•	ooster OR date of adult	☐ Immunization confirmed by titer d	ate:/	<i>J</i>	
immunization:		HB surface antigen □ Positive □ Nega	HB surface antigen □ Positive □ Negative			
☐ Immunization 1 Date			HB surface antibody □ Positive □ Neg			
☐ Immunization 2 Date			Antibody must be positive or immu	inization is required	<u> </u>	
☐ Immunization 3 Date	/		MEDICAL EXEMPTIONS			
			☐ Attach physician's statement of n	nedical contraindic	ations with duration of n	nedical
☐ Last Booster Date::			condition.			
☐ Immunization as an adult	Date:/		CERTIFICATION BY HEALTH CA	RE PROFESSION	Δ1	
POLIO (Polio Immunization is		ge of Dentistry Healthcare			D DO Other	
Providers but IT IS A REQUIRE! (At least three doses of inact	•	PV), live oral poliovirus va	Name of Health Care Provider com			
(OPV), or four doses of any o	•	V.				
☐ Primary Series Completed Immunization 1 Date:/		1 Injection	Name and address of Institution o	r Clinic (or stamp)		
Immunization 2 Date:/						
Immunization 3 Date:/						
Last Booster Date:/_						
☐ Immunization as an adult	OR OR					
☐ Immunization confirmed I						
VARICELLA ZOSTER (CH	ICKEN POX) *Attach	copy of lab report	Phone ()	=ax ()		
☐ Immunization Confirmed	with blood titer		I certify that this information is co			wledge.
Date of titer::/	/ Result:					
☐ Date of re-immunization::	·	/	Signature	Date:/		

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Revised 03/2010