Hartford Hospital
A Hartford HealthCare Partner

FORM B

Hartford Hospital Volunteer Services
Immunization Documentation

Complete the requested information below and also attach a signed copy of your immunization record from your Physician's Office. ***Please do not write "see attached" in lieu of completing the form.**

VOLUNTEER NAME (print):_____**Date of Birth**: _____

If you do not have a record of your immunizations, you may have your physician complete this form. It must include the physician signature, mailing address and phone number.

In the event that vaccination records are unavailable or that immunity has not been verified through titers, you must be vaccinated prior to volunteering.

MMR (Measles, mumps and rubella) **Two doses OR evidence of positive *titer is required for all volunteers**

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Date MMR #1:_____Date MMR #2: _____

OR Date of positive titer_____

***Titer testing or vaccine if necessary, must be obtained through a private physician at the expense of the applicant.**

VARICELLA (Chickenpox) **History of disease OR 2 doses of vaccine OR evidence of positive *titer required**

Date of disease_____OR Dates of immunization #1_____#2 _____

OR Date of positive titer_____

TB TESTING Date skin test given must be within the last 12 months:

Date Given_____Date read_____Result _____

If TB skin test is positive (or volunteer has a history of a positive test or vaccination with BCG):

IGRA test result:_____Date_____

If IGRA test is positive: Chest X-ray result_____Date_____

If Chest X-ray is positive: Date treatment completed _____

***Applicants cannot be cleared to report for volunteer assignments until all necessary immunizations have been completed.**

FLU SHOTS (MANDATORY during Flu Season)

Must be documented for any hospital volunteer who wishes to volunteer during the flu season (generally Oct – May).

Today's Date:_____Date of last flu shot:_____Lot #: _____

If completed by Physician:

Physician Name_____Phone_____

Signature_____Date_____