Jefferson
HOME OF SIDNEY KIMMEL MEDICAL COLLEGE

Jefferson Occupational Health Network
33 S. 9th Street, Suite 205
Philadelphia, PA 19107
Tel: 215-955-6835 / Fax: 215-923-5778
JOHN-CenterCity@Jefferson.edu

Dear Volunteer, Observer or Visiting Student:

Thank you for your interest in joining the Jefferson community.

To safeguard your health and meet regulatory requirements the following are required:

1. Immunization/Vaccine titer review
2. IGRA - Tuberculosis screening (within 3 months of your arrival)
3. COVID vaccination
4. Influenza vaccination (October 1 – April 1)

Approval from Jefferson Occupational Health Network (JOHN) is required prior to the start of your volunteer position/observership.

- Complete all form sections to prevent clearance delay
- Provide copies of titer results where requested on form
- Ask your healthcare prvider to sign the completed document
- Volunteers and Observers are responsible for all required tests and immunization costs
- International Observers: all information must be in English to allow for accurate review

Please email your completed forms to JOHN-CenterCity@Jefferson.edu. Any other questions, your sponsoring office can guide you through the application process.

Sincerely,

Lynn A. Nelson Russom EdD, MSN, CRNP, ANP-BC
Enterprise Sr. Administrative Director
Jefferson Occupational Health Network for Employees and Students (JOHN)

Kenneth M. Lankin MD MBA MPH
Enterprise Medical Director
Jefferson Occupational Health Network

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Student/Volunteer/Observer Immunization Documentation

Name: _____ **Date of Birth** ____/____/____ **Jefferson Start Date** ____/____/____
(Print Clearly)

Address: _____ **Cell Phone:** _____

_____ **Email Address:** _____

PHYSICIAN/APC/RN MUST COMPLETE AND SIGN BELOW.

A. Chicken Pox/Varicella: Proof of immunity will mean two doses of varicella **OR** serologic evidence of immunity.

Immunization dates: #1 _____ # 2 _____
Titer date: _____ **Result (copy must be attached):** ☐ Immune ☐ Not Immune

B. Rubella: Proof of immunity to German measles will mean one dose of the rubella vaccine **OR** serologic evidence of the disease.

Immunization date: _____
Titer date: _____ **Result (copy must be attached):** ☐ Immune ☐ Not Immune

C. Rubeola: Proof of immunity to measles means two doses of live vaccine (after 1968) administered on or after the first birthday, separated by at least one month, **OR** serologic evidence of immunity.

Immunization dates: #1 _____ # 2 _____
Titer date: _____ **Result (copy must be attached):** ☐ Immune ☐ Not Immune

D. Mumps: Proof of mumps immunity means two doses of mumps vaccine administered on or after the 1st birthday **OR** serologic evidence of immunity.

Immunization dates: #1 _____ #2 _____
Titer date: _____ **Result (copy must be attached):** ☐ Immune ☐ Not Immune

E. Tuberculosis Screen: IGRA (Interferon-Gamma Release Assays) blood test

IGRA Date: ____/____/____ (must be within 3 months of arrival) **Result (copy must be attached):** ☐ Positive ☐ Negative ☐ Indeterminate

If IGRA test is positive, a chest x-ray is required. Date: ____/____/____ **(attach a copy of the report)**

F. Influenza Vaccination from current or most recent season (during months of October through March only):
Date of administration: _____ Lot #_____ Manufacturer: _____ Exp. _____

G. Pertussis: Proof of immunity will mean documentation of the Tdap vaccine (tetanus, diphtheria, and pertussis).
Immunization date: _____ (must be within the past 10 years)

H. Hepatitis B: Immunization dates: #1____/____/____ #2____/____/____ #3____/____/____ **AND**
Hepatitis B Quantitative Surface Antibody titer date: ____/____/____ ☐ Immune ☐ Not Immune **(must attach titer results)**

I. COVID-19 Vaccine: Immunization dates: #1 _____/_____/_____ #2 _____/_____/_____ Brand: _____ **OR**

#1 Current COVID Vaccine ____/____/____ Brand _____

Healthcare Provider Signature and Information:
This form has been reviewed and I attest that all information is accurate.

_____ _____
MD/DO/CRNP/PA/RN Signature **Print or Stamp Name**

Address: _____ **Date:** ____/____/____

_____

Revised 6.1.2024