



Immunization Record | Preventive Medicine Service

To be uploaded on the [Application Form](#) at least 40 days before your arrival

This document must be **signed and stamped by your physician**. Without approval of your immunisation record from our hospital you will not be permitted in the hospital wards. Delay in submitting the immunisation records will result in a delay in your mobility.

INSTRUCTIONS:

YELLOW AND **BLUE** SECTIONS ARE MANDATORY, WHERE THE BLUE SECTIONS ARE EMPTY THEN THE **GREEN** SECTION NEEDS TO BE FILLED INSTEAD.
Your last tetanus vaccination needs to be less than 10 years old.

Last Name		First Name	
Date of Birth	_ / _ / _ _ _ _	Estimate date	_ / _ / _ _ _ _
Place of birth		Country	
Immunization/ Vaccination	Vaccine Date dd/mm/yyyy	Serology/Titer	
		dd/mm/yyyy	Results
Measels	1st dose:	/ /	
	2nd dose:	/ /	
Mumps	1st dose:	/ /	
	2nd dose:	/ /	
Rubella	1st dose:	/ /	
Chickenpox	1st dose:	/ /	
	2nd dose:	/ /	
Tetanus	1st dose:	/ /	
	last dose:	/ /	
Hepatitis B	1st dose:	/ /	
	2nd dose:	/ /	
	3rd dose:	/ /	
Hepatitis C		/ /	Results:
QuantiFERON-TB Gold or Skin Test (less than one year)		_ / _ / _ _ _ _	Results:
Chest X Ray (if TB skin test or quantiferon are positive)		_ / _ / _ _ _ _	Results:
Date:	Stamp and Signature of the Physician		
_ / _ / _ _ _ _	_____		