

R# \_\_\_\_\_ NAME \_\_\_\_\_  
Email: \_\_\_\_\_ Phone number: \_\_\_\_\_ Program: Certificate/Second Degree CLS

## TTUHSC SHP Immunizations

**Copies of lab reports, immunizations and/or health records must be provided.**  
**All immunizations and blood work must be submitted by October 15th**  
**TB testing must have last reading after October 1st**

1. **Varicella (Chicken Pox)** Positive Varicella Titer (blood test) **IgG** Date of Test: \_\_\_\_\_ (Attach Report)

**TTUHSC does not accept vaccine for this requirement**

2. **Measles, Mumps, and Rubella (MMR)** Positive MMR titer (blood test) **IgG** Date of Test: \_\_\_\_\_ (Attach Report)

**TTUHSC does not accept vaccine for this requirement**

3. **Tuberculosis:**

**2-STEP TB skin test (last reading must be after October 1st)**

**www.nationaltbcenter.edu**  
**Visit 1, day 1:** Place the 1<sup>st</sup> TST and have the employee return in 7 days for the test to be read.

**Visit 2, day 7:** Place 2<sup>nd</sup> TST on all employees/volunteers whose 1<sup>st</sup> test is negative at 7 days.

**Visit 3, day 9 or 10:** Read the 2<sup>nd</sup> test at 48-72 hours.

**There are different ways of performing the 2 Step TB, we accept any of them**

**1<sup>st</sup> test** Date: \_\_\_\_\_ Result: \_\_\_\_\_ mm

**2<sup>nd</sup> test** Date: \_\_\_\_\_ Result: \_\_\_\_\_ mm

**If positive on TST**

Negative Chest X-Ray if (+) TST Date: \_\_\_\_\_ Result: \_\_\_\_\_

**Chest X-Ray must be no older than 1 year, if TB skin test is positive.**  
(Attach Report)

**TTUHSC will also accept IGRA (T-SPOT or quantiFERON) testing in place of a TB test**

Date: \_\_\_\_\_ Results: \_\_\_\_\_ **(must be after October 1st)**

4. **Hepatitis B :** Positive Hepatitis B titer (**Surface Antibody**): Date of Test: \_\_\_\_\_ (Attach Report)

**TTUHSC does not accept vaccine for this requirement**

5. **Tetanus/diphtheria (Td): Tetanus Diphtheria booster (required within past 10 years)**

Td Date: \_\_\_\_\_ (Tdap will suffice)

6. **Tdap (Tetanus, Diphtheria, and Acellular Pertussis): One time Adult Dose** (these are only good for 10 years, must be good for you entire length of stay)

Tdap date: \_\_\_\_\_

7. **Meningococcal Vaccine (MCV): Adults 22 and younger** (vaccine within the last 5 years)

MCV date: \_\_\_\_\_ circle exemption (age, online)

8. **Influenza Vaccine:** Influenza date: \_\_\_\_\_ **(required during FLU season October- Mar)**

**\*TTUHSC strongly recommends that you be vaccinated for COVID-19. If you have received the COVID-19 vaccine, please document below:**

9. **Covid- 19 Vaccine:** Documentation of 2 doses of Moderna or Pfizer, or one dose of Johnson and Johnson

Dose#1 \_\_\_\_\_ Dose#2 \_\_\_\_\_

**\*COVID-19 VACCINATION MAY BE MANDATORY AT SOME CLINICAL SITES. AT THIS TIME, TTUHSC DOES NOT REQUIRE YOU TO DISCLOSE WHETHER OR NOT YOU HAVE RECEIVED THE COVID-19 VACCINE. HOWEVER, FOR THOSE WHO DO NOT RECEIVE THE VACCINE OR OBTAIN AN APPROVED COVID-19 VACCINE WAIVER, IF APPLICABLE, YOUR ABILITY TO OBTAIN REQUIRED CLINICAL HOURS NECESSARY FOR PROGRAM COMPLETION MAY BE IMPACTED. FOR THOSE WHO WISH TO NOT DISCLOSE, IT WILL BE CONSIDERED THAT YOU HAVE NOT RECEIVED THE VACCINE FOR THE PURPOSES OF ADHERING TO CLINICAL SITE REQUIREMENTS.**

**This completed form and supporting documentation should be forwarded as soon as possible to:**

**Office of Institutional Health- TTUHSC**

**3601 4<sup>th</sup> st MS 8150**

**Immunization Coordinator**

**Lubbock TX 79430**

**fax 806-743-2056 or email to**

**Mecole.Campbell@ttuhsc.edu**

**806-743-7455**