Atlantic Health System
Volunteer Department
HEALTH CERTIFICATE

Volunteer Applicant Name: _____SS #: _____
(Last, First, MI)
Address: _____

Telephone Number: (_____)_____ DOB: _____/_____/_____

1. **Measles, Mumps, Rubella, and Varicella:** The CDC defines immunity to these viruses as one of the following: (1) Appropriate immunization*, (2) positive titer or (3) laboratory confirmation of disease. Given the above definition of immunity, please complete the following information for this individual.

Immunity:
Measles: Yes _____ No _____ Mumps: Yes _____ No _____
Rubella: Yes _____ No _____ Varicella: Yes _____ No _____

***Measles, Mumps, and Rubella Vaccine** (MMR): Two doses of live measles or mumps (or MMR) vaccine, at least 28 days apart, on or after his/her first birthday. Proof of one dose of rubella vaccine after his/her first birthday, except women of childbearing age who have 1 or 2 documented doses of rubella-containing vaccine and have rubella-specific IgG levels that are not clearly positive should be administered 1 additional dose of MMR vaccine (maximum of 3 doses) and do not need to be retested for serologic evidence of rubella immunity. **Varicella Vaccine**: Proof of two doses of the vaccine 4 to 8 weeks apart.

2. **Tdap**: Volunteers age 11 or older must provide evidence of a single dose of Tdap.

3. **Influenza Vaccine:** Required during flu season annually (as defined by the Centers for Disease Control).

4. **Hepatitis B Vaccine:** If you have given this patient the hepatitis B vaccine, please record the dates that it was given.
1st dose: ____/____/____ 2nd dose: ___/____/____ 3rd dose: ____/_____/_____

5. **Tuberculosis Testing:** If you have ever placed a Mantoux Test (TST) on this patient, please record the two most recent test dates and results. If positive, please provide documentation of a chest x-ray and Interferon-Gamma Release Assay (IGRA) if one was drawn.

	Date mo/date/yr	Amount	Result (mm) @ 48-82 hours
1.	_____	_____	
2.	_____	_____	

Health Status: To my knowledge this applicant:

a. Is free from contagious disease and capable of performing all volunteer assignments at an Atlantic Health System hospital. Yes _____ No _____
b. If no, please list what precautions need to be taken and if the volunteer has any restrictions in his or her activities:
_____

7. **Doctor's Name: _____ Doctor's Signature: _____**
8. **Doctor's Address: _____**
9. **Doctor's Phone Number: (____)_____**