ASSABET - PNP
Verification of Immunization Form

Print Student Name: _____ Date: _____/_____/_____

All students are *conditionally* accepted to the Program until all immunity requirements are met, prior to the first day of clinical or acceptance into the program will be withdrawn.

Directions: Provide the dates of the following immunizations or Titer results. Attach all documentation for the purpose of verification by ASSABET-PNP. Your Health Care Provider (HCP) must complete and sign this form.

Disease	Immunity Requirements		Titer Results
Influenza (Flu)	1 dose as soon as available	>	Flu Vaccine Date: _____/_____/_____
TDAP (Tetanus, Diphtheria, Pertussis)	1 does of TDAP vaccine within 10 years	>	TDAP Vaccine Date: _____/_____/_____
MMR (Measles, Mumps, Rubella) – Requires 2 doses of vaccines **OR** 3 positive titers	Dose #1 Date: _____/_____/_____ Dose #2 Date: _____/_____/_____	**OR**	Measles Positive Titer: _____ Mumps Positive Titer: _____ Rubella Positive Titer: _____
Varicella Requires 2 vaccines **OR** 1 positive titer	Vaccine #1 Date: _____/_____/_____ Vaccine #2 Date: _____/_____/_____	**OR**	Varicella Positive Titer: _____
Hepatitis B	Positive Titer Date: _____/_____/_____ ***NEGATIVE** Titer results requires *Hepatitis B Acknowledgement Form*	**OR**	*Complete for **NEGATIVE** Titer only Hepatitis B Acknowledgement Form Signed: _____/_____/_____
Meningococcal	1 dose for any health science student age of 21 or younger	>	Meningococcal Vaccine Date: _____/_____/_____
Tuberculosis Select only 1 screening method (TST **OR** IGA **OR** CXR) and provide required results and date	1 **NEGATIVE** TB Skin Test (TST) within 1 year	>	TST Date: _____/_____/_____ Result: ☐ POSITIVE ☐ NEGATIVE
	1 **NEGATIVE** IGA (t-spot **OR** QuantiFERON) within 1 year	>	IGA Date: _____/_____/_____ Result: ☐ POSITIVE ☐ NEGATIVE Test: ☐ t-spot ☐ QuantiFERON
	☐ History of **Positive** TB	>	**NEGATIVE** Chest X-Ray: _____/_____/_____ (within past 2 years) **OR** Completed only for history of **POSITIVE TB** TB Screening Form Date: _____/_____/_____
			OVER

COVID-19 Need proof showing all COVID vaccinations and boosters.	2 Doses Moderna or Pfizer **OR** 1 Dose Johnson & Johnson **AND** Most up-to-date COVID-19 vaccination.	> **AND**	☐ Moderna ☐ Pfizer Dose #1 Date: _____/_____/_____ Dose #2 Date: _____/_____/_____ **OR** ☐ Johnson & Johnson Dose #1 Date: _____/_____/_____ **AND** Manufacturer: ☐ Moderna ☐ Pfizer Date: _____/_____/_____

Signature* of Examining HPC: _____ Date: _______________
(*Stamp is NOT ACCEPTABLE in place of signature)

Print Name: _____

Office or Agency Name: _____

Address: _____

Telephone Number: _____

The signature below confirms these immunization documents have been provided to the Assabet PN Program and are verified to be complete and accurate.

_____MSN, RN Date: _____/_____/_____
ASSABET - PNP Director