



39600 Garfield Rd. - Suite F
Clinton Twp. MI 48038

P: (586) 228-7100
F: (586) 228-7274

Immunization Verification

This document must be completed by a physician

Applicant Name: _____

Immunizations:

- hepatitis B titer or declination (must fill out Hep waiver)
- proof of MMR x 2 if you were born after 1957 and x 1 if you were born prior to 1957
- varivax is required to be eligible for employment if there is no supporting documentation for the varicella titer or history.

Hepatitis B series

MMR

Varivax

date: _____
date: _____
date: _____

date: _____
date: _____
date: _____

date: _____
-OR- Varicella
Immune by history of disease
date: _____

TB skin test:

date: _____ results: _____ mm

-OR-

Chest x-ray (if TB positive):

date: _____ results: _____

I have examined the individual named above and he/she is in good physical and mental health, free of any communicable diseases, and is able to function in his/her profession at full capacity. By signing above I certify that the information above is valid to the best of my knowledge.

Physician's Name

Physicians Signature

Date

License number

Address