





Professional Student Immunization Requirements

Requirement	Status
COVID-19 Vaccination – Upload your COVID-19 records via the secure Occupational Health Services Portal . You must be logged into a UCSF network or sign on to Pulse Secure VPN. Find out how to access VPN here: https://it.ucsf.edu/service/vpn . You may also email your documentation to vaccineresponsibleoffice@ucsf.edu . The OHS portal is the central repository for the entire UCSF community COVID-19 vaccination data and used for compliance and reporting purposes.	Copy Attached
Option 1	
One or more of the following options: <ul style="list-style-type: none">At least ONE previous COVID-19 Vaccine (Any Brand) AND <ul style="list-style-type: none">A Current Annual COVID-19 Vaccine Compliance (ONE of the options below)<ul style="list-style-type: none">AdministrationDeclinationDeferral	
Option 2	
An approved Exception Request: <ul style="list-style-type: none">COVID-19 Vaccine - Religious exceptionCOVID-19 Medical Exception	






Other Vaccination and Screening Records

Enter dates and upload documentation for MMR, Tdap, Varicella, Hep B and Tuberculosis information into the secure 'New Professional Student Immunizations' tile via the secure [Occupational Health Services Portal](#). Ensure images of your documents are legible and include procedure name, dates, results, and identifying information (name on every page as well as the name of provider of care for that service).

Vaccination is essential for healthcare workers due to their increased exposure to infectious diseases. Staying current with vaccinations protects you from serious illnesses and helps prevent disease transmission to patients and the community. The Centers for Disease Control (CDC) emphasizes the importance of vaccinations in healthcare settings to safeguard both workers and patients. You may be considered for an Exception Request:

- [Vaccine - Religious exception](#)
- [Medical Exception](#)

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MMR (Measles, Mumps, Rubella) – 2 doses of MMR vaccine or two (2) doses of Measles, two (2) doses of Mumps and (1) dose of Rubella; or serologic proof of immunity for Measles, Mumps and/or Rubella. Choose only one option.					Copy Attached
Option 1	Vaccine	Date			
MMR - 2 doses of MMR vaccine	MMR Dose #1	__ / __ / __			
	MMR Dose #2	__ / __ / __			
Option 2	Vaccine or Test	Date			
Measles - 2 doses of vaccine	Measles vaccine Dose #1	__ / __ / __			
	Measles vaccine Dose #2	__ / __ / __			
OR positive Measles serology	Serologic Immunity (IgG, antibodies, titer)	__ / __ / __	Qualitative Titer Results: Quantitative Titer Results:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative IU/ml	
Mumps - 2 doses of vaccine	Mumps vaccine Dose #1	__ / __ / __			
	Mumps vaccine Dose #2	__ / __ / __			
OR positive Mumps serology	Serologic Immunity (IgG, antibodies, titer)	__ / __ / __	Qualitative Titer Results: Quantitative Titer Results:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative IU/ml	
Rubella - 1 dose of vaccine	Rubella vaccine	__ / __ / __			
OR positive Rubella serology	Serologic Immunity (IgG, antibodies, titer)	__ / __ / __	Qualitative Titer Results: Quantitative Titer Results:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative IU/ml	
Tetanus-diphtheria-pertussis – One (1) dose of adult Tdap. Vaccine should be received on or after 11th birthday. If last Tdap was more than 10 years old, provide date of last Td and Tdap.					
	Tdap Vaccine (Adacel, Boostrix, etc.)	__ / __ / __			
	Td Vaccine (if more than 10 years since last Tdap)	__ / __ / __			

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Varicella (Chicken Pox) – 2 doses of vaccine or positive serology					
	Varicella Vaccine #1	___ / ___ / ___			
	Varicella Vaccine #2	___ / ___ / ___			
OR positive Varicella serology	Serologic Immunity (IgG, antibodies, titer)		Qualitative Titer Results: Quantitative Titer Results:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative IU/ml	
Hepatitis B Vaccination – 3 doses of Engerix-B, Recombivax or Twinrix or 2 doses of Heplisav-B followed by a positive Hepatitis B Surface Antibody (titer) preferably drawn 4-6 weeks after 3rd dose. If negative, give a 4th dose and repeat a titer in 4-6 weeks. If negative complete the remainder of the second series followed by another titer drawn 4-6 weeks after the last dose of the second series. If Hepatitis B Surface Antibody is still negative after a secondary series, additional testing including Hepatitis B Surface Antigen should be performed. Documentation of Chronic Active Hepatitis B is for rotation assignments and counseling purposes only.					Copy Attached
Primary Hepatitis B Series Heplisav-B only requires 2 two doses of vaccine followed by antibody testing	3-dose vaccines (Engerix B, Recombivax or Twinrix)		3 Dose Series	2 Dose Series	
	2 dose vaccines (Heplisav-B)				
	Hepatitis B Vaccine Dose #1	___ / ___ / ___	___ / ___ / ___		
	Hepatitis B Vaccine Dose #2	___ / ___ / ___	___ / ___ / ___		
	Hepatitis B Vaccine Dose #3	___ / ___ / ___			
	Hep B Surface Antibody	___ / ___ / ___		<input type="checkbox"/> Positive <input type="checkbox"/> Negative	
Secondary Hepatitis B Series <u>Only if no response to primary series</u> Heplisav-B only requires 2 two doses of vaccine followed by antibody testing			3 Dose Series	2 Dose Series	
	Hepatitis B Vaccine Dose #4	___ / ___ / ___	___ / ___ / ___		
	Hepatitis B Vaccine Dose #5	___ / ___ / ___	___ / ___ / ___		
	Hepatitis B Vaccine Dose #6	___ / ___ / ___			
	Hep B Surface Antibody	___ / ___ / ___		<input type="checkbox"/> Positive <input type="checkbox"/> Negative	
Hepatitis B Vaccine Non-responder (If Hepatitis B Surface Antibody Negative after Primary and Secondary Series)	Hepatitis B Surface Antigen	___ / ___ / ___		<input type="checkbox"/> Positive <input type="checkbox"/> Negative	
	Hepatitis B Core Antibody	___ / ___ / ___		<input type="checkbox"/> Positive <input type="checkbox"/> Negative	
Chronic Active Hepatitis B	Hepatitis B Surface Antigen	___ / ___ / ___		<input type="checkbox"/> Positive <input type="checkbox"/> Negative	
	Hepatitis B Viral Load	___ / ___ / ___		copies/ml	

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TUBERCULOSIS SCREENING – HISTORY DEPENDENT. COMPLETE ONE SECTION ONLY.						
Section A: (History of Negative TB Screening) At least one IGRA (QuantiFERON or T-SPOT) blood test performed <u>within three (3) months of first date on campus.</u>						
Section B: (Two PPD Skin Tests) Most recent performed within three (3) months of first date on campus.						
Section C: (History of Positive TB Screening) Documentation of positive testing, treatment if any, and a chest x-ray performed <u>within three (3) months of first date on campus.</u>						
Section D: (History of Active TB Disease) All fields completed. Chest x-ray must be performed <u>within three (3) months of first date on campus.</u>						
Please complete only one TB section based on your history	Section A			Date	Result	Copy Attached
	T-Spot or QuantiFERON TB Gold blood tests for tuberculosis	QuantiFERON TB Gold or T-Spot (Interferon Gamma Releasing Assay)		__ / __ / __	<input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate	
		QuantiFERON TB Gold or T-Spot (Interferon Gamma Releasing Assay)		__ / __ / __	<input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate	
	Section B		Date Placed	Date Read	Result	
	Two PPD Skin Tests performed by either method	Two PPD skin tests placed 7-31 days apart in the three months preceding entry into school.	__ / __ / __ __ / __ / __	__ / __ / __ __ / __ / __	__ mm __ mm	
		Documentation of a TB skin test completed within the three months prior to starting school and documentation of an additional skin test completed within one year of the more recent test.	__ / __ / __ __ / __ / __	__ / __ / __ __ / __ / __	__ mm __ mm	
	A PPD skin test must be placed the SAME day as a live virus vaccine OR at least 28 days after the administration of a live virus vaccine to be considered valid.					
	Section C		Date Placed	Date Read	Result	
	History of Latent Tuberculosis, Positive Skin Test or Positive Blood Test IGRAs include T-Spots or QuantiFERON TB Gold blood	Positive Test	__ / __ / __	__ / __ / __	__ mm	
				Date	Result	
		QuantiFERON TB Gold or T-Spot (Interferon Gamma Releasing Assay)		__ / __ / __	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate	
		Chest X-ray		__ / __ / __		
Treated for latent TB?				<input type="checkbox"/> Yes <input type="checkbox"/> No		
If treated for latent TB, list medications taken:						
Total Duration of treatment latent TB?				__ Months		



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	<u>tests for</u> tuberculosis	Date of Last Annual TB Symptom Questionnaire	__ / __ / ____	
Tuberculosis Screening History Continued				
	Section D		Date	
	History of Active Tuberculosis	Date of Diagnosis	__ / __ / ____	
		Date of Treatment Completed	__ / __ / ____	
		Date of Last Annual TB Symptom Questionnaire	__ / __ / ____	
		Date of Last Chest X-ray	__ / __ / ____	