Hartford HealthCare
The Hospital of Central Connecticut

Hartford HealthCare
MidState Medical Center

Campus to volunteer at: □ MSMC □HOCC □ BMH

Complete the requested information below <u>and also</u> attach a signed copy of your immunization record from your Physician's Office. *Please do not write "see attached" in lieu of completing the form.

VOLUNTEER NAME (print):_____

Date of Birth: _____

It must include the physician signature, mailing address and phone number.

<u>MMR</u> (Measles, mumps and rubella) Two doses <u>OR</u> evidence of positive titer is required for all volunteers

Two doses OR evidence of positive titer is required for all volunteers

Date MMR #1:_____Date MMR #2: _____

OR Date of positive titer_____

<u>VARICELLA</u> (Chickenpox) History of disease <u>OR</u> 2 doses of vaccine <u>OR</u> evidence of positive titer required

Date of disease_____OR Dates of immunization #1_____#2 _____

OR Date of positive titer_____

<u>INFLUENZA:</u> Proof of flu vaccine during flu season

<u>Tdap</u>: Proof of one dose of Tdap (Tetanus-Diptheria-Pertussis) administered at or after the age of 18.

<u>COVID:</u>

Dates of initial doses #1: _____ #2: _____

Manufacturer: _____

Booster dose Date: _____ Manufacturer: _____

In the event that vaccination records are unavailable, you must have immunity verified through blood titers, and if necessary you must be vaccinated prior to volunteering. Please inquire with the Volunteer Services staff contact for instructions on how to schedule an appointment at the hospital.

<u>TB TESTING</u> One skin test or Quantiferon blood test completed must be within the last 12 months:

Date Given____Date read_____Result _____

If TB skin test is positive (or volunteer has a history of a positive test or vaccination with BCG):

IGRA test result:_____Date_____

If IGRA test is positive: Chest X-ray result_____Date_____

If Chest X-ray is positive: Date treatment completed _____