TEXAS TECH UNIVERSITY
HEALTH SCIENCES CENTER™
Paul L. Foster School *of* Medicine

To: Incoming Residents

From: Occupational Health Department

Subject: **Immunizations and CPR**

As you are preparing to come to El Paso, there are some requirements related to immunizations and CPR that must be met before you can begin your residency training.

The **Immunization Requirements** are as follows: TB skin test or CXR if positive Tb skin test, Tdap vaccine, Hepatitis B series (3 doses), Influenza vaccine, and titers providing proof of immunity to Varicella, Rubeola, Rubella and Hepatitis B.

Attached to this memo is a copy of our "Immunization and Health Survey" form. You ***MUST complete this form****, attach copies of laboratory reports* and immunization records, and *return* to the Graduate Medical Education Department in care of Irene Barriga. We need your e-mail address on this form so we can communicate directly with you regarding any immunization questions.

Please come to the Occupational Health Office – basement of the Clinic Building, Suite B04 – as soon as you arrive in El Paso so we can review your immunization records with you to assure that you have met all of the requirements.

CPR Certification (BLS, ACLS, PALS – as specified by each residency program) is required prior to your starting at UMC-El Paso. Please send us a copy of your current card(s).

If you have any questions about any of the items mentioned above, please feel free to call or e-mail Maria Ramirez at (915) 215-4429 or maria.ramirez@ttuhsc.edu.

Thank you in advance for completing these important items prior to your orientation on our campus. We look forward to seeing you in June!

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Occupational Health Department

Immunization and Health Survey

____
Last Name (Please Print) **First** **Middle Initial** **Social Security Number**

____
Date of Birth (Mo/Day/Yr) **Department** **Contact Phone #**

Provision of immunization documentation as noted below is one of the requirements for training at TTUHSC-EP (**Policy: EP 7.1, 7.1A**) and the affiliated hospital University Medical Center of El Paso.

- **Copies of lab reports, immunizations and/or health records must be provided.**
- **All results must be in English from a U.S. lab.**

1. Varicella: Must show proof of immunity, verified by blood titer.
   Date of Titer: ____________ Result: _____________ **(Attach copy of lab report)**
   In the event of a negative titer, two doses of Varicella vaccine at least 28 days apart is required.
2. Measles (Rubeola): Must show proof of immunity, verified by blood titer.
   Date of Titer: ____________ Result: _____________ **(Attach copy of lab report)**
   In the event of a negative titer, two doses of MMR at least 28 days apart is required.
3. Rubella: Must show proof of immunity, verified by blood titer.
   Date of Titer: ____________ Result: _____________ **(Attach copy of lab report)**
   In the event of a negative titer, two doses of MMR at least 28 days apart is required.
4. Mumps: Two doses of MMR vaccine **OR** Documented Mumps immunity-titer
   MMR #1-Date __________ MMR# 2-Date _____________ **(Attach documentation)**
   -OR- Date of Titer: ____________ Result: _____________ **(Attach copy of lab report)**
   In the event of a negative titer, two doses of MMR at least 28 days apart is required.
5. Tuberculosis Testing (PPD): (Two-step testing is required)
   #1. Date placed:___________ Result _____ (mm) #2. Date placed: ___________ Result: _____ (mm)
   If *positive TB skin test,* a Chest X-Ray (within three months) is required:
   CXR Date:_____________ CXR Result: _________ **(Attach copy of X-ray report)**
   Students with positive TB skin test must show documentation of positive test and will be required to meet with TT-PLFSOM Infection control Nurse.
6. Hepatitis B: Hepatitis B series **AND** proof of immunity
   Dose #1___________ #2 __________ #3 ___________ **(Attach documentation)**
   -AND- Hepatitis B Surface Ab: Date of Titer:___________ Result:_________ **(Attach copy of lab report)**
   In the event of a negative titer after the initial series, a second series and re-titer will be required,
7. Tetatus/Diphteria/Pertussis: (Tdap vaccine) Date: _____________ **(Attach documentation)**
8. Influenza Vaccine: (when in season ~ generally Sept through Feb) Date: ______________
9. List major Illnesses (if any): ____
10. Medications: ____
11. Allergies: ____
12. Emergency Contact:____
    Name **Current Phone #**

*__e-mail address – in case we need to contact you:__ ____

You may NOT begin your training at TTUHSC/University Medical Center of El Paso until all above requirements are completed.