TULANE UNIVERSITY SCHOOL OF MEDICINE

DEPARTMENT/SECTION:__________________________RESIDENCY/FELLOWSHIP PROGRAM
1430 Tulane Avenue, New Orleans, Louisiana 70112

IMMUNIZATION DATA:

Please indicate the date (mm/dd/yy) of immunization for each of the following:

Hepatitis B 1. ________/________/________

2. ________/________/________

3. ________/________/________

Measles/Mumps/
Rubella ________/________/________

Chicken Pox ________/________/________

TEST DATA:

Date of Last
TB Skin Test* ________/________/________
Results – positive or negative *(circle one)*

(Hospital regulations require TB testing within six months of reporting for duty and every year thereafter while in training.)

________/________/________
Date Signed

____
Signature of Resident Physician

____
PRINT Full Name

________/________/________
Date Resident/Fellow is expected
to complete training in this program.

*Available at TUHC, Occupational Medicine,
Telephone (504) 586-3986

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Rev. 2/05