

TULANE UNIVERSITY SCHOOL OF MEDICINE

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

2005-2006

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.