



Medical Certificate for Occupational Activities at the University Hospital in Magdeburg (Immunization/Serology Record Form)

All fields must be completed with requested information, or entire form will be rejected. Please submit this certificate before you start your practical work.

Name:	Date of birth:
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Kind of intended activity at the University Hospital Magdeburg (please tick where applicable):

- Observation with observation contract (Hospitation) [visiting students/observer status] ()
- Internship with enrolment [exchange students/contact with hospital patients] ()
- Training with German medical license [visiting physician with contract/contact with hospital patients] ()
- Research [Ph.D. students/graduands with contract/no contact with patients] ()

Clinic/Institute: _____

From _____ To _____

This is to certify that above-named person has the following results, and a suitable immunization protection can be evidenced:

Measles/ Mumps/ Rubella

(Proof of immunization is necessary if visiting the pediatrics, gynecology, infectiology)

	Authentication of physician Date/Signature
Minimum of two immunizations has been carried out.	
or	
Serological evidence of a protection against Measles, Mumps and Rubella is existent.	

Varicella

(Proof of immunization is necessary if visiting the pediatrics, gynecology, oncology, infectiology and if working with immunocompromised/immunosuppressed patients)

	Authentication of physician Date/Signature
<input type="checkbox"/> Serological evidence of a protection against Varicella is existent.	
<input type="checkbox"/> Already diseased with Varicella.	

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Hepatitis C / Anti HIV

(Serotest is necessary if operating or working invasively)

	Authentication of physician Date/Signature		Authentication of physician Date/Signature
<input type="checkbox"/> Anti-HCV positive		<input type="checkbox"/> Anti-HCV negative	
	Authentication of physician Date/Signature		Authentication of physician Date/Signature
<input type="checkbox"/> Anti-HIV positive		<input type="checkbox"/> Anti-HIV negative	

Hepatitis B Series

(Three [3] immunisations or positive Anti HB > 100 IU/l are required if contact with potentially infectious human material, inter alia blood, serum).

Series
1 date _____
2 date _____
3 date _____

Authentication of physician
Date/Signature

Serological evidence is existent (Anti-HBs > 100 IU/l or Anti-HBc positive).

Date: _____ Titer: _____

Tuberculosis

	Authentication of physician Date/Signature
<input type="checkbox"/> No Tuberculosis	

Result of the medical examination:

This is to certify that Ms/Mr
is healthy and sane and exempt from contagious diseases.

Date

Name, signature and stamp of
physician

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Bemerkungen PÄD des Universitätsklinikums Magdeburg:

Gegen einen Einsatz von Frau/ Herrn
in der Klinik:
im Institut:
gibt es:

<input type="checkbox"/>	Keine gesundheitlichen Bedenken
<input type="checkbox"/>	Keine gesundheitlichen Bedenken unter bestimmten Voraussetzungen*
<input type="checkbox"/>	gesundheitliche Bedenken*

***Bemerkungen:**

Ort, Datum, Unterschrift, Stempel