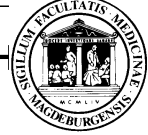
Universitätsklinikum Magdeburg A.ö.R.
Personalärztlicher Dienst



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

All fields must be completed with requested information, or the entire form will be rejected. Please make sure to **submit this certificate office at latest 8 weeks <u>before</u> you start your practical work.** It should **not be older than 6 month** before you start your practical work**.**
Please make sure it contains the Hep-Titer.

Name:	Date of birth:

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

Internship [visiting students/contact with hospital patients] ( )
Clinical Elective/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/graduates 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:

<u>Measles/ Mumps/ Rubella</u>
(Proof of immunization is necessary if visiting the pediatrics, gynecology, infectiology) <u>Please tick the appropriate box!</u>

	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.	

<u>Varicella</u>
(Proof of immunization is necessary if visiting the pediatrics, gynecology, oncology, infectiology and if working with immunocompromised/immunosuppressed patients) <u>Please tick the appropriate box!</u>

	Authentication of physician Date/Signature
□ Serological evidence of a protection against Varicella is existent.	
□ Already diseased with Varicella.	

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Hepatitis C / Anti HIV
(Serotest is necessary if operating or working invasively) Please tick the appropriate box!

	Authentication of physician Date/Signature		Authentication of physician Date/Signature
☐ Anti-HCV positive		☐ Anti-HCV negative	

	Authentication of physician Date/Signature		Authentication of physician Date/Signature
☐ Anti-HIV positive		☐ Anti-HIV negative	

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

Series — Authentication of physician Date/Signature

1 date ________________________

2 date ________________________

3 date ________________________

Serological evidence is existent (Anti-HBs > 100 IU/l or Anti-HBc positive).
Date:_______________________ Titer: __________________________

Tuberculosis

	Authentication of physician Date/Signature
☐ 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:

□	Keine gesundheitlichen Bedenken
□	Keine gesundheitlichen Bedenken unter bestimmten Voraussetzungen*
□	gesundheitliche Bedenken*

***Bemerkungen:**

Ort, Datum, Unterschrift, Stempel