Weill Cornell Medicine

Immune Assessment Form for Volunteers

Only to be completed for volunteers who wish to serve for one month or less.

Weill Cornell Medicine requires that all volunteers show proof of immunity for Rubella, Measles, Mumps, and Varicella in the form of assays of anti-viral antibodies or immunization records. **History of having any of these diseases in the past is not sufficient proof of full immunity**. In addition, a PPD test is required unless one has been performed in the last month. If you will be working in a laboratory or clinical setting where human blood, blood products or other human bodily fluids are used, federal regulations require that volunteers show proof of immunity to Hepatitis B in the form of assays of anti-viral antibodies or immunization records. If the Hepatitis-B test is negative and you decline to be immunized, federal regulations require that you sign a waiver of immunization.

This form must be filled out by the volunteer's primary care provider. Any attachments cannot be used as a substitution for filling out this form. If any part of the form is incomplete or pending, the volunteer will not be allowed to start regardless of his/her start date.

Regarding travel to any countries that are labeled as CDC's Warning Level 3 (Avoid Nonessential Travel) due to 2019-novel Coronavirus/SARS-CoV-2/COVID-19 or other infectious diseases (check one; if needed, check the travel country name at the following CDC website: https://wwwnc.cdc.gov/travel/notices):

□ **I have NOT traveled to those countries over the last 14 days.**

□ **I have traveled to one of those countries over the last 14 days:**

Name of travel country:_____travel start date __/__/__; travel end date: __/__/___

Volunteer's Name (Last, First, Middle Initial)	**Date of Birth**

ANTIBODY TITERS

TEST	TEST DATE	RESULTS
Rubella	____ / ____ / ____	
If negative, date of vaccination:	____ / ____ / ____	
PPD (**done within the last 30 days**). …date	____ / ____ / ____	Result in mm_____
If positive, date of conversion (if known):	____ / ____ /____	
CXR	____ / ____ /_____	____
BCG	____ / ____ /____	
Measles	____/ ____ /____	
If negative, date of vaccination:		
#1	____ / ____ /_____	
#2	____ / ____ /_____	(if born after 1/1/57)
Mumps	____/____ / ____	
If negative, date of vaccination:	____ /____ /____	
Varicella	____/____ /____	
Hepatitis-B	___ / ____ /____	
If negative, dates of vaccination:		
#1 ____ /____ / ____	#2 ____/ ____ / ____	#3 ____ / ____/_____

or Volunteer must sign the following statement:

I have been offered the vaccine and have declined to receive it.

Signature _____ **Date** _____

EXAMINING HEALTH PROFESSIONAL'S STATEMENT

I have determined that the above named is free from any communicable disease which is of potential risk to patients, employees or students or which might interfere with the performance of volunteer duties.

Name (Please Print)	Occupation	State License No.

Address	Telephone Number
Signature	Date