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Dear Doctor / Immunisation Provider,

Medical Students working within the healthcare setting are required to provide immunisation and health screening records to

* Ensure contractual obligations to Grampians Health and
* Protect agency staff from acquiring vaccine preventable diseases and from transmitting infections to vulnerable contacts.

The checklist on page 2 outlines the necessary immunisation and health screening requirements prior to employment at Grampians Health and is consistent with

Australian Technical Advisory Group on Immunisation (ATAGI). Australian Immunisation Handbook, Australian Government Department of Health and Aged Care, Canberra, 2022, immunisationhandbook.health.gov.au

If an agency / locum staff member is a Non-Responder to Hepatitis B, please provide a medical certificate outlining the dates of vaccination and that implications of not being protected in the event of a blood or body fluid exposure have been explained to the staff member.

Your assistance is greatly appreciated.

Sue Flockhart

Director –Infection Prevention and Control / Workforce Immunisations

Grampians Health

**IMMUNISATION SCREENING CHECKLIST**

Position on card

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **EMPLOYEE (PRINT CLEARLY)** | | | | | |
| **SURNAME** | | | **FIRST NAME** | | |
| **DOB** | | | **MOBILE:** | | |
| **ADDRESS** | | | | | **POSTCODE** |
| *Please enter Medicare card number including the position on card (in the last square)*   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | **Medicare Number** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   **OR**   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | **IHI Number** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | | | | | |
|  | | | | | |
| **All sections** of this form are mandatory and must be completed by your immunisation provider or the form will be rejected. This form must be completed and returned before commencement of employment | | | | | |
| **VACCINATION / HEALTH SCREENING REQUIREMENT** | | **ACCEPTABLE EVIDENCE OF IMMUNITY AND DOCUMENTATION**  **(Please tick box to indicate evidence provided)** | | | |
| **HEPATITIS B** | | Serology result indicating immunity to Hepatitis B  ( **antibody** level >10mIU/mL | | | |
| **DIPTHERIA/TETANUS/ PERTUSSIS** | | One documented adult dose of **dTpa** vaccine within the  last 10 years. (**ADT vaccination is not acceptable)** | | | |
| **MEASLES** | | Documented evidence of 2 doses of MMR vaccine given  **OR**  Documented evidence of positive IgG for Measles serology | | | |
| **MUMPS** | | Documented evidence of 2 doses of MMR vaccine given  **OR**  Documented evidence of positive IgG for Mumps serology | | | |
| **RUBELLA** | | Documented evidence of 2 doses of MMR vaccine given  **OR**  Documented evidence of positive IgG for Rubella serology | | | |
| **VARICELLA** | | Documented evidence of 2 doses of Varicella vaccine given  **OR**  Documented evidence of positive IgG for Varicella serology | | | |
| **ANNUAL INFLUENZA vaccine** | | Date most recent received: | | | |
| **Service Provider / Nurse Immuniser Declaration** | | | | | |
| **Service Provider / Nurse Immuniser**  **Name and Contact Details**  ( PLEASE PRINT OR STAMP )  INC. **PROVIDER NUMBER** |  | | | | |
| *I, the undersigned declare that the Health care worker immunisation requirements specified above*  *have been assessed and actioned.* | | | | | |
| **Signature** *of Service Provider*:  ***NOT*** *signed by applicant*. | | | | **Date:** | |