Medizinische Hochschule Hannover

IMMUNIZATION AND SCREENING REQUIREMENTS FOR VISITING PHYSICIANS

(Results should not be older than 6 months.)

Name :
Date of last examination:
Significant findings:

	Date of vaccination	Titer : Date and result
Hepatitis B *		
Hepatitis C		
Rubella *		
Measles *		
Varicella *		
Polio *		

(* Immunity is required against following diseases.)

ASL / SGOT	
AST / SGPT	

Signed: ______________________________
(Signature of Physician)

Institute / Hospital: ________________________

Address: ______________________________

Date: ____________ Stamp: ____________

Please return immediatly to:

Postal address: Medizinische Hochschule Hannover
Betriebsärztlicher Dienst – OE 0040
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