



HEALTH QUESTIONNAIRE

Gesundheitsfragebogen

Given Name/Vorname:	Surname/Nachname:
Date of Birth/Geburtsdatum:	Nationality/Nationalität:

(to be completed by the family/company doctor)

(vom Haus-/Betriebsarzt auszufüllen)

Requirement Voraussetzung	Documentation required gewünschte Dokumentation	Result submitted Ergebnis vorgelegt <small>(Tick as applicable - zutreffendes ankreuzen)</small>	Remarks Bemerkungen
HEPATITIS B			
Evidence of immunity	Documented vaccination (at least 2 doses, last dose at least two weeks before the start of the training/work placement) OR Hepatitis B surface antibody (anti-HBs) result Please attach copies of results <i>(in English)</i>	<input type="checkbox"/> Vaccination records <input type="checkbox"/> anti-HBs > 100 IU/ml	
TUBERCULOSIS Tuberkulose			
Free from active infection	Mantoux test OR Interferon-Gamma test Please attach copies of results dated within the previous 3 months <i>(in English)</i>	<input type="checkbox"/> negative Mantoux test <input type="checkbox"/> negative Interferon-Gamma test	
MEASLES/MUMPS/RUBELLA Masern, Mumps, Röteln			
Evidence of immunity	Documented vaccination (2 doses) OR Result of antibody titer to measles, mumps and rubella Please attach copies of results/certification <i>(in English)</i>	<input type="checkbox"/> Vaccination records <input type="checkbox"/> Measles titer <input type="checkbox"/> Mumps titer <input type="checkbox"/> Rubella titer	



VARICELLA Windpocken			
Evidence of immunity	Definite recollection of past infection OR Documented vaccination (2 doses) OR Result of antibody titer to varicella Please attach copies of results/certification (in English)	<input type="checkbox"/> Declaration <input type="checkbox"/> Vaccination records <input type="checkbox"/> Varicella titer	
TETANUS, DIPHTHERIA, PERTUSSIS, POLIOMYELITIS Tetanus, Diphtherie, Keuchhusten, Poliomyel.			
Evidence of immunity	Documented primary immunisation (at least 4 doses) Please attach copies of results/certification not older than 10 years (in English)	<input type="checkbox"/> Vaccination records	
HEPATITIS A			
Evidence of immunity	Documented vaccination (at least 1 dose) OR Result of antibody titer to Hepatitis A Please attach copies of results/certification (in English)	<input type="checkbox"/> Vaccination records <input type="checkbox"/> Hepatitis A titer	
Any other serious medical conditions OR planned vaccinations prior to the start of the clerkship			

I hereby confirm that the above mentioned applicant is physically and mentally fit and has no infectious diseases.

Signature: _____

Name (Capitals): _____

Position: _____

Date: _____

