

Immunization Requirements

for students and guests in the clinical area with patient contact

Family name(s):	First name(s):
Date of birth (dd.mm.yyyy):	Austrian Social Security Number (if available):
Student ID number (if available):	Application Procedure number (if available):

Upon joining the Medical University of Graz, you must have immunity against the infectious diseases mentioned below for your own protection and the protection of patients. Your immunity must be verified either by vaccination (immunization) or/and a positive titer determination. The form must be signed by a physician on pages 1, 2 and 3. The "Declaration" on page 3 has to be signed by you.

Compulsory vaccinations

	11 (111)		
Measles/Mumps/Rub	ella (MMR)		
MMR vaccine	Two doses: yes no	Date of first vaccination:	Date of second vaccination:
If not vaccinated twice, the antib	ody titers have to be determined:	l	L
Measles	Titer:	Date of titer determination:	Vaccination recommended: yes no
Mumps	Titer:	Date of titer determination:	Vaccination recommended: yes no
Rubella	Titer:	Date of titer determination:	Vaccination recommended: yes no
Varicella (VZV)			
VZV vaccine	Two doses: yes no	Date of first vaccination:	Date of second vaccination:
If not vaccinated twice, the antib	ody titers have to be determined:		
Titer:		Date of titer determination:	Vaccination recommended: yes no
Hepatitis B (vaccination	dates, titer and booster rec	commendation required)	
Hep B vaccine	Date of first vaccination:	Date of second vaccination:	Date of third vaccination:
Titer:	Date of titer determination:	Booster recommended on:	Vaccination recommended: yes no
Confirmation by a ger	neral practitioner/boar	d certified doctor	
, ,	•	munity against the infectiou	s diseases
Date		Stamp and signature of a	a physician



Date

Tuberculosis
Should you come from one of the countries listed below or another region endemic for tuberculosis, a doctor has to prove (please provide him*her with a chest x-ray not older than 2 months) that you are not suffering from tuberculosis.
Afghanistan, Armenia, Azerbaijan, Bangladesh, Belarus, Bulgaria, China, Congo, Estonia, Ethiopia, Georgia, India, Indonesia, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Moldavia, Myanmar, Nigeria, Pakistan, Philippines, Russia, South Africa, Tajikistan, Ukraine, Uzbekistan, Vietnam
Confirmation by a general practitioner/board certified doctor (if necessary)
I confirm that currently there is no evidence of an infection with mycobacterium tuberculosis.

Stamp and signature of a physician

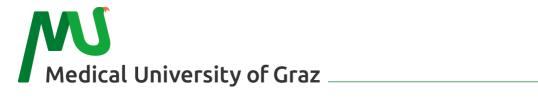
Compulsory information on voluntary vaccination 1,2

•	yes	Date of last vaccination:	Vaccination recommended:
	no		yes
			no
Poliomyelitis yes no	yes	Date of last vaccination:	Vaccination recommended:
	no		yes
			no
Diphtheria	yes	Date of last vaccination:	Vaccination recommended:
	no		yes
			no
Tetanus	yes	Date of last vaccination:	Vaccination recommended:
	no		yes
			no
Hepatitis A	yes	Date of last vaccination:	Vaccination recommended:
	no		yes
			no
i i	l		
Confirmation by	y a general pr	ractitioner/board certified	l doctor
Confirmation by	y a general pr	actitioner/board certified	l doctor
		actitioner/board certified ntly sufficient immunity against	
l hereby confirm th			
I hereby confirm th			
l hereby confirm th			

¹ It is mandatory to provide the information, even if the vaccinations are not mandatory for your stay. Voluntary vaccinations should be

updated according to your national vaccination recommendations.

For Hepatitis A recommendation is two doses of a Hepatitis A vaccine (e.g. Havrix 1440, Avaxim, Epaxal) or three doses of a Hep A/B combination (e.g. Twinrix).



COVID-19 Vaccination (with EMA approved vaccine)³

COVID-19 vaccination received	Date of first dose:	Date of second dose:			
	Date of third dose:	Date of last booster or planned date:			
Confirmation by	a general practitioner	/board certified doctor			
		OVID-19 vaccination is correct.			
Date		Stamp and signature of a physician			
	eu/en/human-regulatory/overview /covid-19-vaccines-authorised	/public-health-threats/coronavirus-disease-covid-19/treatments-			
Declaration of	the student/doctor/gu	est			
By signing this document					
☑ I understand that I may not be permitted to perform the tasks of my stay (including coursework) at Med Uni Graz on the clinical premises of Steiermärkische Krankenanstaltengesellschaft m.b.H. (KAGes) hospitals if the proof of compulsory immunization as indicated above is missing/insufficient. This procedure follows the guideline 2000.0100 of the KAGes.					
☑ I agree that my personal data regarding the proof of immunization will be stored and processed by the Medical University of Graz as long as necessary for the purpose of monitoring compliance with KAGes guideline 2000.0100. This confirmation can be withdrawn at any time.					
studies/research no neglect of submittir	or for damage to health or ar ng the immunization record	Graz will not compensate me for delays in the course of my other damage to myself or to a third party caused by the or by obtaining the necessary vaccinations. I will indemnify ss from and against claims of third parties arising hereof.			
Date		Signature			

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