



# HEALTH SCREENING ASSESSMENT FOR FOREIGN PRACTITIONERS AT NIPPON MEDICAL SCHOOL

## Visiting Student, Researcher, Nurse

(All questions must be answered)

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### ■ Tuberculosis Screening:

Results of last **2** TB skin tests (PPDs) **or** **1** IGRA blood test (T-spot or QFT) are required regardless of prior BCG status.

(TB testing or QFT must have been performed in the last twelve (12) months)

	Date Placed	Date Read	Reading (mm)	Interpretation
PPD #1	/ /	/ /		<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Equiv
PPD #2	/ /	/ /		<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Equiv
	Date	Result		
IGRA (T-spot or QFT)	/ /	<input type="checkbox"/> Neg <input type="checkbox"/> Undetermined <input type="checkbox"/> Pos		

If TB skin test or QFT was positive, what were the chest x-ray results? \_\_\_\_\_

The chest x-ray was taken on \_\_\_ / \_\_\_ / \_\_\_ at \_\_\_\_\_

If TB skin test or QFT was positive, a chest x-ray (PA/RL) has to be taken in the last 6 months (for new applicants).

Did you receive any treatment? Yes No

If yes, describe type and dates of diagnosis and treatment

	Date	
Date of Diagnosis	/ /	Please attach certification.
Date of Treatment Completed	/ /	
Date of Last TB symptoms	/ /	
Date of Last Chest X-ray	/ /	

Do you have any of the following symptoms?

- Persistent cough(longer than 2 weeks) YesNo
- Blood streaked sputum YesNo
- Weight loss(unrelated to dieting) YesNo
- Night sweats YesNo
- Unusual fatigue for more than 2 weeks YesNo
- Unexplained fevers YesNo

### ■ Influenza Vaccine:

	Date	
● 1 dose annually each fall	/ /	

**■ Immune Status of Measles, Mumps, Rubella and Varicella:**

According to Japanese guidelines, the following vaccinations are recommended: **2** doses of Measles, Mumps, Rubella and Varicella vaccine; **or** serologic proof of immunity of Measles, Mumps, Rubella and Varicella.

Please have documentation available if requested.

	Vaccine	Date	
Measles ● 2 doses of vaccine <b>or</b> positive serology	Dose #1	/ /	The titer greater than <b>16.0</b> is considered as a positive test.
	Dose #2	/ /	
	IgG, antibody titer	/ /	Titer
Mumps ● 2 doses of vaccine or positive serology	Dose #1	/ /	The titer greater than <b>4.0</b> is considered as a positive test.
	Dose #2	/ /	
	IgG, antibody titer	/ /	Titer
Rubella ● 2 doses of vaccine or positive serology	Dose #1	/ /	The titer greater than <b>8.0</b> is considered as a positive test.
	Dose #2	/ /	
	IgG, antibody titer	/ /	Titer
Varicella ● 2 doses of vaccine <b>or</b> positive serology	Dose #1	/ /	The titer greater than <b>4.0</b> is considered as a positive test.
	Dose #2	/ /	
	IgG, antibody titer	/ /	Titer

**■ Immune Status of Hepatitis B:**

3 doses of vaccine followed by a quantitative Hepatitis B surface antibody (titer) 4-8 weeks after 3<sup>rd</sup> dose is recommended. If negative, you need to complete a second Hepatitis B series followed by a repeat titer. If the Hepatitis B surface antibody is negative after the 2<sup>nd</sup> series again, you are regarded as a non-responder to HBV vaccine.

	HBV Vaccine	Date	
<b>Primary Hepatitis B Series</b>	Dose #1	/ /	The titer greater than <b>10.0</b> is considered as a positive test.
	Dose #2	/ /	
	Dose #3	/ /	
	HBs antibody titer	/ /	Titer mIU/mL
<b>Secondary Hepatitis B series</b> (If no response to primary series)	Dose #1	/ /	The titer greater than <b>10.0</b> is considered as a positive test.
	Dose #2	/ /	
	Dose #3	/ /	
	HBs antibody titer	/ /	Titer mIU/mL

**■ Health Statement:**

To the best of my knowledge, I am free of any infectious disease and am safe to be around immune-compromised patients.

Name (print) \_\_\_\_\_ Date of Birth \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

Reviewed by \_\_\_\_\_ Date \_\_\_\_\_

(To be completed by your doctor)

Signature \_\_\_\_\_ Date \_\_\_\_\_