Dok. Nr.	Bereich	Dok. Typ.	Dokumententitel
tk_AM008	**tk_A**	**FO**	**Infektionsschutznachweis (englisch)**
Geltungsbereich:			Alle Bereiche/Häuser der **tirol kliniken**
Zielgruppe:			• Alle **tirol kliniken** Mitarbeiter:innen • Alle Med. Univ. Ibk. (MUI) Mitarbeiter:innen, die in den **tirol kliniken** tätig sind • Alle sonstigen Personen, die in den **tirol kliniken** tätig sind
Zweck / Ziel:			Dieses Formular dient zum Infektionsschutznachweis und ist Voraussetzung für eine Einstellung, Beschäftigung oder Tätigkeit in den **tirol kliniken**.

PROOF OF INFECTION PROTECTION

For your own protection and that of our patients, immunity to measles, mumps, rubella, and varicella is required. Complete protection against infection is only guaranteed with **two documented** measles/mumps/rubella and varicella vaccinations or a **sufficient antibody** titer!

If possible, this form should be submitted to your general practitioner 6 weeks before starting work so that any necessary vaccinations can be caught up on.

For assessment purposes, the completed and confirmed proof of infection protection must be submitted to the respective **tirol kliniken** occupational health department (**enclose laboratory results and a copy of your vaccination card**).

The information will be documented internally by occupational health department and the assessment will be forwarded to the relevant department.

1. Data Applicant / Proof provider (Please fill in using BLOCK LETTERS)	
First name + family name	
Insurance no. / Date of birth	
E-mail-adress	
Mobil no.	
tirol kliniken Location and department	
Planned activity (at **tirol kliniken**)	

2. Required proof of infection protection (This section is to be completed by your general practitioner)				
PATHOGEN	**Date 1st vaccination**	**Date 2nd vaccination**	**Alternativ antibody titer** **(date + value or pos/neg)**	**Immunity to be assumed**
MEASLES				☐ **Yes** ☐ **No**
MUMPS				☐ **Yes** ☐ **No**
RUBELLA				☐ **Yes** ☐ **No**
VARICELLA				☐ **Yes** ☐ **No**
…… Place, date		…… Signature and stamp general practitioner		

3. Desired proof of infection protection	
HEPATITIS B Vaccinationstatus	
Vaccination	Date 1st vaccination …… Date 2nd vaccination …… Date 3rd vaccination …… Date last booster shot ……
Antibody titer	Date: …… Value: ……

4. Recommended vaccination	
Diphteria, tetanus, pertussis, polio	Vaccine name: …… Last vaccination on: ……
Hepatitis A	1. Vaccination on: …… 2. Vaccination on: …… Booster vaccination, on: ……
Influenza (seasonal recommended)	Last vaccination on: ……

5. Declaration Applicant / Proof provider

I confirm with my signature, that all information provided is true, that all documents (l**ab results, copy of vaccination card**) have been enclosed and that this information may be used within **tirol kliniken** for further processing.

…… ……

Date First name + family name (using BLOCKLETTERS)

……

Signature

Änderungsverzeichnis (Dokumenthistorie)

Rückfragen zu Dokument-Metadaten (Vorversionen, Autor:innen, Prüfung, Freigabe, Änderungen) unter lki.arbeitsmedizin@tirol-kliniken.at