



School of
Health
Professions

PA STUDIES TITERS/VACCINATION DOCUMENTATION

**Upload this form with the lab
report to your Castle Branch folder.**

Please keep the original documents.

To be completed by student:

Name: _____
(First, Middle Initial, Last)

Date of Birth: _____
(Month, Day, Year)

I understand and accept that

- the healthcare facilities that I may be assigned to for clinical rotations or other patient experiences, have immunization requirements for their healthcare workers as a condition of employment. As a guest in their facilities, the New York Institute of Technology Physician Assistant Studies (NYIT, PA Studies) program's student participants must comply with all healthcare screening and other requirements imposed as a condition of the healthcare affiliation agreement.
- if I am unable to confirm immunization status or unable to obtain immunizations due to personal, religious or medical* reasons, NYIT's PA Studies program cannot guarantee placement at a clinical site, and this may limit my ability to successfully complete and graduate from the program as completion of all clinical rotations is required for successful completion of the program.

*In some situations, the clinical site might accept certain medical reasons for not receiving a vaccination, but this will be at the discretion of the site.

Signature: _____ Date: _____

To be completed by healthcare professional: **(PLEASE UPLOAD A COPY OF LAB REPORTS)**

1. MMR Titers	<u>Numerical Value</u>	<u>Date of Titer</u>
Measles Ab (IgG):	_____	_____
Mumps Ab (IgG):	_____	_____
Rubella Ab (IgG):	_____	_____
2. Hepatitis B (S Ab) Titer	_____	_____
3. Varicella Ab (IgG) Titer	_____	_____

4. Tetanus, diphtheria, and acellular pertussis (Tdap) vaccination or booster

Date of Vaccination/Booster: _____ (NOTE: Date must be within 10 years)

5. Meningococcal vaccination: ☐ Yes - Date of Vaccination: _____
☐ No - Please attach Meningococcal Meningitis Vaccination Response form

Signature of PA, Physician, or Certified Nurse Practitioner

Print or Type Name Telephone Number

Date: _____

Address & Stamp of Provider/ Health Facility (Required)