Medical University of Graz

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 by either vaccination (immunization) or 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

Measles/Mumps/Rubella (MMR)			
MMR vaccine	Two doses: ☐ yes ☐ no	Date of first vaccination:	Date of second vaccination:
If not vaccinated twice, the antibody titers have to be determined:			
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 antibody titers have to be determined:			
Titer:		Date of titer determination:	Vaccination recommended: ☐ yes ☐ no
Hepatitis B (vaccination dates, titer and booster recommendation 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 general practitioner/board certified doctor

I confirm that there is currently sufficient immunity against the infectious diseases mentioned above.

Date

Stamp and signature of a physician

Medical University of Graz

COVID-19 Vaccination (with EMA approved vaccine)[1]		
COVID-19 vaccination received	Date of first dose:	Date of second dose:
	Date of third dose:	Date of last booster or planned date:
COVID-19 vaccination so far not received	Vaccination not possible for medical reasons. A medical confirmation is enclosed.	

Confirmation by a general practitioner/board certified doctor

I hereby confirm that the information on the COVID-19 vaccination is correct.

Date

Stamp and signature of a physician

[1] https://www.ema.europa.eu/en/human-regulatory/overview/public-health-threats/coronavirus-disease-covid-19/treatments-vaccines/vaccines-covid-19/covid-19-vaccines-authorised

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.

Date

Stamp and signature of a physician

Medical University of Graz

Compulsory information on voluntary vaccinations[4,5]

Pertussis	☐ yes ☐ no	Date of last vaccination:	Vaccination recommended: ☐ yes ☐ no
Poliomyelitis	☐ yes ☐ no	Date of last vaccination:	Vaccination recommended: ☐ yes ☐ no
Diphtheria	☐ yes ☐ no	Date of last vaccination:	Vaccination recommended: ☐ yes ☐ no
Tetanus	☐ yes ☐ no	Date of last vaccination:	Vaccination recommended: ☐ yes ☐ no
Hepatitis A	☐ yes ☐ no	Date of last vaccination:	Vaccination recommended: ☐ yes ☐ no

Confirmation by a general practitioner/board certified doctor

I hereby confirm that the information on voluntary vaccinations is correct.

Date _____ Stamp and signature of a physician _____

[4] 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.
[5] For Hepatitis A recommendation is two doses of a Hepatitis A vaccine (e.g. Havrix 1440, Avaxim, Epaxal) or three doses of a HepA/B combination (e.g. Twinrix).

Declaration of the student/doctor/guest

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.

☒ I understand that the Medical University of Graz will not compensate me for delays in the course of studies/research nor for damage to health or any other damage to myself or to a third party caused by the neglect of submitting the immunization record or by obtaining the necessary vaccinations. I will indemnify and hold the Medical University of Graz harmless from and against claims of third parties arising hereof.

Date _____ Signature _____

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