Rocky Mountain University of Health Professions

PHYSICIAN ASSISTANT PROGRAM - IMMUNIZATION FORM

Last Name: ______________________ First Name: ______________________ Middle Initial: __________

Date of Birth (*mm/dd/yyyy*): __________________

Telephone Number: _____________________________ E-mail: _________________________________

Instructions for Completing Provider (MD, DO, PA, or NP)**:** Please complete and review the evidence for each risk below to **confirm adequate immunity status based on vaccination and/or titer**.

Proof of Immunity Documentation

Risk	Program Requirement	Evidence		
		Titer Results*	Vaccine and Date Administered	Vaccine and Date Administered
Measles, Mumps, and Rubella (MMR)	2 doses of measles and mumps, at least 1 dose of rubella **OR** Titer validating immunity.	Measles Y N Mumps Y N Rubella Y N	Vaccine Type: Date: Date of Titer: _______	Vaccine Type: Date:
Varicella	2-dose vaccine series at least 28 days apart **OR** Titer validating current immunity.	Immune: Y N Date of Titer: ________		
Tdap	At least 1-dose Tdap within the last 10 years.			
COVID-19	Complete series in line with CDC guidance.		Vaccine Name/Type: Date:	Vaccine Name/Type: Date:
Hepatitis B	Titer validating current immunity (≥ 10mIU/ml)	Immune: Y N	Date of Titer: _______	Note: If titer suggests no immunity, the student should initiate another vaccination series and reach out to the program to complete an additional Hepatitis B Form.

* The RMUoHP PA program does not require submission of titer lab results.

Provider signature: ____ Date: ___________________
Licensed Medical Provider (MD, DO, PA, NP)

Name and **credentials** of signing provider (please print): _______________________________________

Clinic or Address of signing provider: ____