Precautions for Preparing Vaccination History and Antibody Test Reports

Medical institutions must monitor infectious diseases and ensure that healthcare workers (including trainees and interns) are vaccinated to prevent contracting infectious diseases themselves and transmitting them to patients. When participating in training or internships at our hospital, you are required to undergo the designated tests and vaccinations.

※ Please record your vaccination history from the age of one onwards, referring to your Maternal and Child Health Handbook or school certificates.

※ Even if you have previously submitted this information for training or internships at our hospital, please resubmit it.

※ If you are unable to receive vaccinations due to allergies or other reasons, please submit the separate "Vaccination Exemption Declaration Form."

○ Tuberculosis (TB) Prevention

- A chest X-ray taken within one year prior to the start of the internship is required to confirm the absence of findings suggestive of TB(required).
- If you have had a cough lasting more than two weeks or a low-grade fever within one month before the internship, visit a medical institution for a chest X-ray and submit proof of no abnormalities to the General Affairs Section by the start of the internship.（学務版はここを学務に）
- If the internship extends beyond one year after the examination, you may need to undergo another chest X-ray and submit the results.
- An interferon-gamma release assay (Quantiferon (QFT) or T-SPOT.TB) is recommended as an additional TB evaluation.
- If the chest X-ray shows findings suggestive of TB, participation in training or internships will not be permitted until active TB is ruled out.

○ Hepatitis B, measles, rubella, varicella, and mumps,

Please follow the guidelines based on the 4th edition of the Vaccination Guidelines for Medical Professionals published by the Japanese Society for Infection Prevention and Control.

- **Hepatitis B** (Not required if there is no possibility of direct contact with patients or exposure to blood or body fluids.)

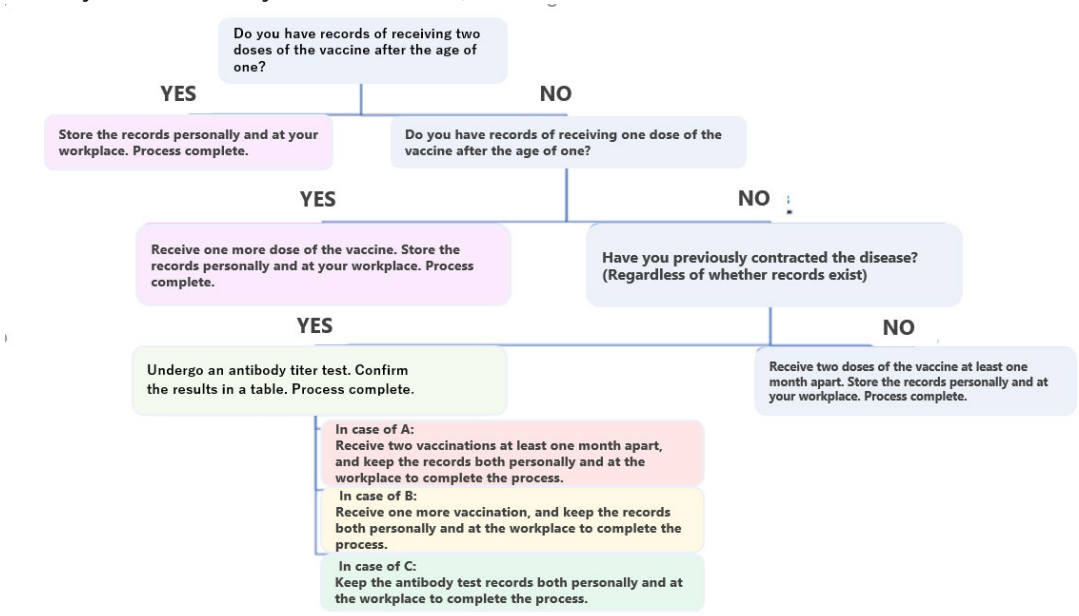
1) Those who have already been confirmed to have an antibody level of 10 mIU/ml or higher after undergoing an HBs antibody test 1-2 months after completing their third vaccination.
No hepatitis B vaccination is required.

2) For others
Please receive three doses of the vaccine, and have your antibody levels tested one month after receiving the third dose.

※Consider administering another series of vaccinations to healthcare workers who did not acquire immunity after one series.

• Measles, Rubella, Varicella, Mumps

Please make your determination based on the following flowchart. If records show that you have received two vaccinations for each disease after the age of one, antibody testing is not necessary. If you have not received two vaccinations or your vaccination history is unclear, please have your antibody levels tested.



MMRV Vaccine Guidelines for Healthcare Workers – Flowchart Translation

When measuring antibody titers, please make a determination based on the following criteria. If the antibody titer is not positive (does not meet the criteria), please consider vaccination in accordance with the flowchart above. Please note that all vaccines for these four diseases are live vaccines, so they cannot be administered to people who are pregnant or have immune system disorders, as vaccination is not appropriate in such cases.

Name of Disease	Methods	Judyement of Serum Ab Titer		
		A : Negative (-)	B : Insufficient positive (±)	C : Positive (+)
		Boost is necessary	Single immunization is necessary	No immunization is required
Measles	EIA(IgG)	< 2	>=2, < 16	>= 16
Rubella	HI	< 1 : 8	1 : 8, 1 : 16	>= 1 : 32
Varicella	EIA(IgG)	< 2	>=2, < 8	>= 8
	EIA(IgG)	< 2	>=2, < 4	>= 4
	IAHA	< 1 : 2	1 : 2	>=1 : 4
Mumps	EIA(IgG)	< 2	>=2, < 4	>= 4

- If you undergo an antibody test, please be sure to use the specified testing method, as results obtained using other methods will not be accepted.
- If you do not meet the criteria for all items or have not completed vaccination by the start of the internship, participation in some or all of the internship may be restricted.
- Please allow sufficient time to complete vaccination, as it may take a certain period of time.
- If you are unable to receive the vaccination or have any questions, please consult the General Affairs Section of the General Affairs Office.

【Contact Information】

(Regarding submission of documents, deadlines, and other matters related to the internship)

Medical and Hospital Management Department, General Affairs Section

TEL: +81-59-231-5428

(Consultations regarding infection control)

Department of Infection Control and Prevention

TEL: +81-59-232-1111 ext. 5658

Vaccination History and Antibody Test Report

To: Director, Mie University Hospital

Date:

Traininginstitutionname/Medicalinstitutionname:

Name:

Please review and complete the relevant sections below, referring to vaccination records in your Maternal and Child Health Handbook and medical examination data from medical institutions.

Tuberculosis:

（A chest X-ray examination is mandatory. QFT (QuantiFERON) or T-SPOT testing is recommended.）

Examination items	Date	Result	Remarks
Chest X-ray	（ / / ） ※Examination required within one year prior to the start of training	Findings suggestive of tuberculosis: Yes / No	
QFT/T-SPOT （Circle one）	（ / / ）	• Negative • Pending • Positive • Inconclusive	

Hepatitis B

（The vaccine should be administered in three doses (at 0, 1, and 6 months). Antibody levels should be measured one month after the third dose.）

Vaccination ※Three doses required	Date	Method （Circle one）	Result	Date of additional vaccination
Date of first shot： （ / / ）	（ / / ）	• EIA • CLIA • CLEIA • Other （ ）	antibody titer mIU/mL	（ / / ）
Date of second shot： （ / / ）				（ / / ）
Date of third shot： （ / / ）	Inconclusive		≧10.0mIU/mL ＜10.0mIU/mL	（ / / ）
Inconclusive				

（＊ Enter the numerical value in the upper row, and mark the judgment with a circle in the lower row.）

Continued on the back

Measles, Rubella, Varicella, Mumps

(If you have not received two vaccinations after the age of one, or if your vaccination history is unknown, please take an antibody test.)

Name of Disease	Vaccination	Date of Examination	Method (Circle one)	Result*	Date of additional vaccination
Measles	Date of first shot : (/ /)	(/ /)	• EIA(IgG)	antibody titer	(/ /)
	Date of second shot : (/ /)			• Negative • Pending • Positive	(/ /)
	Inconclusive				
Rubella	Date of first shot : (/ /)	(/ /)	• EIA(IgG) • HI	antibody titer	(/ /)
	Date of second shot : (/ /)			• Negative • Pending • Positive	(/ /)
	Inconclusive				
Varicella	Date of first shot : (/ /)	(/ /)	• EIA(IgG) • IAHA	antibody titer	(/ /)
	Date of second shot : (/ /)			• Negative • Pending • Positive	(/ /)
	Inconclusive				
Mumps	Date of first shot : (/ /)	(/ /)	• EIA(IgG)	antibody titer	(/ /)
	Date of second shot : (/ /)			• Negative • Pending • Positive	(/ /)
	Inconclusive				

(* Enter the numerical value in the upper row, and mark the judgment with a circle in the lower row.)

I hereby certify that the above vaccination history and antibody test results have been verified.

Physician`s signature_____

Physician`s name (in block capitals)_____

Name of institution_____

Address_____ Date_____

Vaccinations and antibody titer testing are required for all individuals who will enter Mie University Hospital.

Vaccination Exemption Declaration Form

To: Director, Mie University Hospital

Date: _____

Training institution name/Medical institution name: _____

Name: _____

I hereby declare my exemption from the vaccination listed below.
I understand the risk of infection associated with this exemption, and I still wish to participate in clinical training.

1. Vaccines that cannot be administered
   (Please check the applicable vaccine)

   Hepatitis B ・ Measles ・ Rubella ・ Varicella(Chickenpox) ・ Mumps

2. Reason for inability to receive vaccination
   (Please check the applicable vaccine)

   (1) Pregnancy

   (2) Vaccine allergy or underlying medical condition

   (3) Other:
   [(Please specify above)]

※ For reason(1), please attach a copy of the maternal and child health handbook.
※ For reason(2), please attach a medical certificate from a physician

If the reason for inability to receive vaccination is resolved, please promptly receive the vaccination and submit the vaccination record.

Vaccination History and Antibody Test Report

To: Director, Mie University Hospital

Date: 2025/6/16

Traininginstitutionname/Medicalinstitutionname: Edobashi University

Name: Hanako Yamada

Please review and complete the relevant sections below, referring to vaccination records in your Maternal and Child Health Handbook and medical examination data from medical institutions.

Tuberculosis:

(A chest X-ray examination is mandatory. QFT (QuantiFERON) or T-SPOT testing is recommended.)

Examination items	Date	Result	Remarks
Chest X-ray	(2025/ 6/ 1) ※Examination required within one year prior to the start of training	Findings suggestive of tuberculosis: Yes / (No)	
QFT/(T-SPOT) (Circle one)	(2025/ 6/ 1)	• (Negative) • Pending • Positive • Inconclusive	

Hepatitis B

(The vaccine should be administered in three doses (at 0, 1, and 6 months). Antibody levels should be measured one month after the third dose.)

Vaccination ※Three doses required	Date	Method (Circle one)	Result	Date of additional vaccination
Date of first shot : (2024/11/20)	(2025/ 6/ 1)	• EIA • (CLIA) • CLEIA • Other ( )	antibody titer 55.4mIU/mL	(/ /)
Date of second shot : (2024/12/18)				(/ /)
Date of third shot : (2025/ 4/30)	Inconclusive		≧10.0mIU/mL ＜10.0mIU/mL	(/ /)
Inconclusive				

(* Enter the numerical value in the upper row, and mark the judgment with a circle in the lower row.)

Continued on the back

Measles, Rubella, Varicella, Mumps

(If you have not received two vaccinations after the age of one, or if your vaccination history is unknown, please take an antibody test.)

Name of Disease	Vaccination	Date of Examination	Method (Circle one)	Result*	Date of additional vaccination
Measles	Date of first shot : (2021/11/ 7) Date of second shot : (2006/10/ 11) Inconclusive	(/ /)	• EIA(IgG)	antibody titer • Negative • Pending • Positive	(/ /) (/ /)
Rubella	Date of first shot : (2002/ 4/ 17) Date of second shot : (/ /) Inconclusive	(2024/ 4/ 1)	• EIA(IgG) • HI	antibody titer 8 • Negative • Pending • Positive	(2024/4/20) (/ /)
Varicella	Date of first shot : (2002/ 5/ 20) Date of second shot : (/ /) Inconclusive	(2024/ 4/ 1)	• EIA (IgG) • IAHA	antibody titer <2 • Negative • Pending • Positive	(2024/5/30) (/ /)
Mumps	Date of first shot : (/ /) Date of second shot : (/ /) Inconclusive	(2024/ 4/ 1)	• EIA (IgG)	antibody titer <2.0 • Negative • Pending • Positive	(2024/7/15) (2024/9/25)

(* Enter the numerical value in the upper row, and mark the judgment with a circle in the lower row.)

I hereby certify that the above vaccination history and antibody test results have been verified.

Physician`s signature_____

Physician`s name (in block capitals)_____Taro Yamada_____

Name of institution_____Tsu University Hospital_____

Address__Edobashi, Tsu City, Mie Prefecture, Japan_____ Date___2025/6/10

Vaccinations and antibody titer testing are required for all individuals who will enter Mie University Hospital.