COMPLETE IF NON-IMMUNITY IS INDICATED ON THE "TITER & VACCINATION " FORM

School of Health Professions

PA STUDIES
Non-Immune Status Documentation

Upload this form with the lab report to your Castle Branch folder. Please keep the original documents.

If any titer is 'Non-Immune' or negative for any of the required immunizations or tests students must comply with the Center for Disease Control recommended vaccines for healthcare workers: https://www.cdc.gov/vaccines/adults/rec-vac/hcw.html.
Please enter the dates of your vaccinations and titer into the Tracking System, and have your healthcare provider complete, sign and date this NYIT Non-Immune Status form

To be completed by student

Student Name: ________________________________ Date of Birth: ____________________

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 THE RELEVANT LAB REPORTS)***

1. MMR non-immunity: If non-immune (negative titer) for MMR vaccine please follow the CDC recommendations for healthcare workers. https://www.cdc.gov/vaccines/adults/rec-vac/hcw.html.
Please have your health care provider indicate the dates and vaccines given and certify the form below.

MMR Dose #1:	____/____/____	MMR Dose #2:	____/____/____
Measles Dose #1:	____/____/____	Measles Dose #2:	____/____/____
Rubella Dose #1:	____/____/____	Mumps Dose #1:	____/____/____

The student must repeat the blood antibody titer test(s) and submit **a dated laboratory report** to be considered compliant. The report **must** include the laboratory name and address, the student's name and date of birth, the numerical result(s), and the numerical interpretation ranges.

MMR Titers	**Numerical Value**	**Date of Titer**
Measles Ab (IgG):	____________________	____/____/____
Mumps Ab (IgG):	____________________	____/____/____
Rubella Ab (IgG):	____________________	____/____/____

EXEMPTION FROM MEASLES, MUMPS, and RUBELLA VACCINATION (legibly check ✓ the applicable box):

☐ Birth Exception (born prior to January 1, 1957): ______________(date)

☐ Medical Exception: _____**Temporary** ____**Permanent**
(check ✓ either Temporary or Permanent **AND** attach medical documentation supporting this exemption)

2. Hepatitis B (S Ab) non-immunity:

(1) If you do not have documented evidence of a complete hepB vaccine series or if you do not have an up-to-date blood test that shows you are immune to hepatitis B (i.e., no serologic evidence of immunity or prior vaccination) then you should:

- Get a 3-dose series of Recombivax HB or Engerix-B (dose #1 now, #2 in 1 month, #3 approximately 5 months after #2) or a 2-dose series of Heplisav-B, with the doses separated by at least 4 weeks:

  HepB 3 dose series: (Recombivax HB or Engerix-B)

  #1: ____ /____ / ____ #2: ____ /____ / ____ #3: ____ /____ / ____

  OR: **HepB 2 dose series: (Heplisav-B)**

  #1: ____ /____ / ____ #2: ____ /____ / ____

- **FOLLOWED BY**:
  An anti-HBs serologic test 1-2 months after the final dose.

  Hepatitis B (S Ab) Titer: Numerical Values:___________ Date of Titer: ____ /____ / ____

(2) If the HbsAB titer is 'Non-Immune' after the 3 **OR** 2 shot series, the student should have an additional shot for Hepatitis B to become 'Immune' and re-titer for HbsAB. If after fourth the (4) Hep B shot and the following HbsAB titer, the student is still 'non-immune', submit all 4 dates of shots along with above required titers. **Decline:** Students declining the series must submit a Hep B Declination Form AND all three laboratory Hep B titers stated previously to CastleBranch for processing.
For non-responders: HCP who are non-responders should be considered susceptible to HBV and should be counseled regarding precautions to prevent HBV infection and the need to obtain HBIG prophylaxis for any known or probable parenteral exposure to hepatitis B surface antigen (HBsAg)-positive blood or blood with unknown HBsAg status. It is also possible that nonresponders are people who are HBsAg positive. HBsAg testing is recommended. HCP found to be HBsAg positive should be counseled and medically evaluated.

3. Varicella Ab (IgG) non-immunity:

If the titer shows to be 'Non-Immune', the student must then have two (2) doses of varicella vaccine, 4 weeks apart. The student must repeat the blood antibody titer test and submit a dated laboratory report to be considered compliant. The report must include the laboratory name and address, the student's name and date of birth, the numerical result(s), and the numerical interpretation ranges.

Varicella Dose #1: ____ /____ / ____ **Varicella Dose #2:** ____ /____ / ____

Varicella Ab (IgG) Titer Numerical Values: ___________ Date of Titer: ____ /____ / ____

Please enter the dates of your vaccinations and titer into the Tracking System, and have your healthcare provider complete, sign and date this form indicating the information below. Please submit the completed form, AND the lab work printout for your titer, to CastleBranch for processing.

HEALTH CARE PROVIDER INFORMATION:

Name (Print): ________________________________

Signature: ________________________________

Phone #: ________________________________

Address and stamp of provider (required)

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