



DEPARTMENT OF THE ARMY
 HEADQUARTERS, DWIGHT DAVID EISENHOWER ARMY MEDICAL CENTER
 FORT GORDON, GEORGIA 30905-5650

Certification of Immunizations

Name Last _____ First _____ Middle Initial _____

REQUIRED IMMUNIZATION INFORMATION:

Vaccine	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	Lab Result/Date
MMR ¹				Result: _____
Varicella ¹				Result: _____
Tdap ² /Tetanus-Diphtheria-Pertussis				
Td ² – Tetanus Booster				
Influenza ³				
Hepatitis B ⁴				Result: _____
TST ⁵ or ⁶ or ⁷ (Tuberculin Skin Test)	Result: ____ mm Placed: Read:	Result: ____ mm Placed: Read:	Result: ____ mm Placed: Read:	

¹ **MMR** – two doses or positive lab result required

¹ **Varicella** - two doses or positive lab result required

² **Tdap** - One adult dose of Tdap required, thereafter Tetanus Diphtheria (Td) booster every 10 years.

³ **Influenza** - required annually, September through May

⁴ **Hepatitis B Series** - Series of 3 doses required at 0, 1, and 6 months or positive lab result.

⁵ **TST**- Must have 2 negative TSTs within the last year and the most recent one **within 90 days of training**. Provide both results. **OR**

⁶ Two or more previous documented negative TSTs greater than 12 months old, a single TST within **90 days** of training is required. Provide all three results. **OR**

⁷ For positive TST history, a negative chest x-ray report and a physician statement indicating absence of active tuberculosis disease is required.

CERTIFICATION OF HEALTH CARE PROVIDER (This information is required)

Mandatory Office or Healthcare Provider Stamp

Name: _____ Signature: _____

Office Address: _____

Phone: _____ Date: _____