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**Osaka University Dental Hospital**

**Clinical Training Course**

**Notification of Vaccination and Chest X-ray Test Results**

1. Applicant Personal Details (Please complete in block capitals)

|  |  |
| --- | --- |
| Family Name : | Date of Birth : YY/ MM/DD |
| Given Name(s) : | Sex: Male Female |

2. Please state the date of vaccinations. For those who have not had either of those vaccinations, please be sure

to take Antibody Test instead and state its date and result.

|  |  |  |  |
| --- | --- | --- | --- |
| Category | Vaccination Date  | Antibody Test | Results |
| Rubella | YY/MM/DD | YY/MM/DD | Positive Reserved Negative |
| Measles | YY/MM/DD | YY/MM/DD | Positive Reserved Negative |
| Chicken Pox | YY/MM/DD | YY/MM/DD | Positive Reserved Negative |
| Mumps | YY/MM/DD | YY/MM/DD | Positive Reserved Negative |
| Hepatitis B | YY/MM/DD | YY/MM/DD | Positive Reserved Negative |

3. Chest X-ray Test Result

|  |  |
| --- | --- |
| Test Date | Abnormalities |
| YY/MM/DD | Yes　　　　　　　　　　 　No |

I hereby report the above results are accurate.

Applicant’s Signature Date

Director’s Signature Date

\*Caution

If your antibody test results do not come out to be “positive”, or you cannot receive the vaccination in time, we may restrict your participation in some or all parts of the course.

If abnormalities are found by Chest X-ray examination, we may restrict your participation in some or all parts of the course until you are found negative for active tuberculosis.