Immunity Information Request

This form must be completed to the best of your knowledge with evidence to support, or by your Occupational Health Department or your GP and be stamped by them at the bottom of the form. It should then be returned to us.

Personal Details
Name: _____
Date of Birth: _____
Signature for Consent: _____

Test	Result	Date
☐ BCG (scar seen)		
☐ Heaf/Mantoux		
☐ Hepatitis B (1st)		
☐ Hepatitis B (2nd)		
☐ Hepatitis B (3rd)		
☐ Hepatitis B Booster		
☐ Hepatitis B Surface Antigen		
☐ Hepatitis B Surface Antibodies		
☐ Hepatitis C (if working in EPP areas)		
☐ HIV (if working in EPP areas)		
☐ Measles		
☐ Mumps		
☐ Rubella		
☐ Varicella Zoster		

On behalf of EXCELLENT STAFFING SOLUTIONS thank you for completing this form. The information helps us to comply with the Department of Health requirements for our healthcare staff to work both in the community and within hospitals.

Signature of person
Completing the form:_____

Status of Signatory: _____

Date:_____

Department Stamp