

Dok. Nr.	Bereich	Dok. Typ.	Dokumententitel
<b>2108</b>	<b>LKI</b>	<b>FO</b>	<b>Attestation of protection against infectious diseases</b>

Required for work at the A. ö. Landeskrankenhaus (Univ.-Kliniken) Innsbruck.

**This form must be completed by your General Practitioner.**

**Dear Sir/ Madam,**

In the interest of your own protection and that of patients, it is imperative that you are immunised against measles, mumps, rubella, varicella and COVID-19. We appreciate your understanding in this matter.

_____	_____
First name and family name	Insurance no. and date of birth
_____	_____
Residential address	Email address
_____	_____
Telephone number	Matriculation number (for students)

**You must provide proof of protection against the following infectious diseases through either two doses of vaccine or a positive antibody titer.**

### Requisite attestation of protection against infectious diseases

**Measles**

Date of 1st vaccine                      Date of 2nd vaccine                      **OR**                      positive IgG antibody titer

**Mumps**

Date of 1st vaccine                      Date of 2nd vaccine                      **OR**                      positive IgG antibody titer

**Rubella**

Date of 1st vaccine                      Date of 2nd vaccine                      **OR**                      positive IgG antibody titer

**Varicella**

Date of 1st vaccine                      Date of 2nd vaccine                      **OR**                      positive IgG antibody titer

**COVID-19**

Date of 1st vaccine                      Date of 2nd vaccine                      **OR**                      positive antibody titer

**Please turn over**

When working in certain areas with immunocompromised patients an annual influenza vaccination is also compulsory for the period between the beginning of October and the end of March.

**Influenza vaccination**                      yes                      no                      If so, when? \_\_\_\_\_

I herewith confirm that Ms/ Mr \_\_\_\_\_, at the time of the examination on (date) \_\_\_\_\_, possessed the requisite protection against infectious diseases obligatory for working with and around patients.

\_\_\_\_\_  
Place, date

\_\_\_\_\_  
Doctor's signature and stamp

## Requested protection

### Hepatitis B vaccination

You will receive information on Hepatitis B immunity during your pre-employment medical examination.

## To be completed by the applicant

With my signature I hereby confirm that all the information I have provided is true. Furthermore, I give my consent to my vaccination status being forwarded to Tirol Kliniken GmbH.

\_\_\_\_\_  
Place, date

\_\_\_\_\_  
Applicant's signature

## Administrative provisions

### Employment

The fully-completed form must be submitted in person during the pre-employment medical examination to the Occupational Medical Care Department (Betriebsärztliche Betreuung).

### Work placement

A copy of this attestation must be submitted to the office of the Medical Director or Nursing Director at least two weeks before commencement of the work placement.

### Students of Innsbruck Medical University (MUI)

This form must be submitted by the end of your first year academic year at the latest to the Department of Teaching and Academic Organisation (Lehr- und Studienorganisation). A copy must also be submitted to the hospital as necessary (see Clinical Practical Year (KPJ), Medical Elective).

### Compulsory Medical Elective (Pflichtfamulatur)

This attestation must be submitted when registering with the relevant human resources department.

### Clinical Practical Year (KPJ) in a Tirol Kliniken GmbH facility

This attestation must be submitted when signing the Clinical Practical Year (KPJ) agreement.