EXAMPLE

Certificate of Infection Control

実習用 Form1

Name: Hoa Thi Nguyen

Company/ University: Hanoi University Dental School

Date of birth: Apr/2/1991

Age: 27

Sex: Female

		Vaccination*	Date (M/D/Y)
4 Pediatric Viral Infections	Measles 麻疹	Dose 1	5 / 3 / 1992
		Dose 2	4 / 25 / 1996
	Mumps ムンプス	Dose 1	5 / 3 / 1992
		Dose 2	4 / 25 / 1996
	Rubella 風疹	Dose 1	5 / 3 / 1992
		Dose 2	4 / 25 / 1996
	Varicella (Chickenpox) 水痘	Dose 1	5 / 3 / 1992
		Dose 2	10 / 6 / 1992

* If date of vaccination was copied from MCH handbook or other vaccination record, submission of a copy of the original document is required. (All the documents must be translated in English.)

	Blood test **	Date (M/D/Y)	Result **Submission of a copy of test result is required.
Hepatitis B B型肝炎	HBs Ab	/ /	☐ Positive (10≧mIU/ml) / ☐ Negative
	Vaccination*	Date (M/D/Y)	
	Dose 1	6 / 12 / 1991	
	Dose 2	7 / 10 / 1991	
	Dose 3	11 / 27 / 1991	

NOTE: Please fill **EITHER** "blood test" or "vaccination record".

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	History of infection 感染歴		
Tuberculosis 結核		☑ No / ☐ Yes (Month and Year: /)	
	IGRA test	✓ Date (M/D/Y)	Result
		6 / 5 / 2018	☐ Positive / ☑ Negative / ☐ Indeterminate 判定保留
	Method of testing	☑ QuantiFERON-TB / ☐ T-SPOT.TB	

	Vaccination	Date (M/D/Y)	
Influenza インフルエンザ		/ /	NOTE: Only visitors from Oct. 1st ~ the end of Feb. are required. ☑ Visiting period doesn't include Oct~Feb.

- Please attach a copy of your vaccination record or medical check reports (all the documents must be translated in English). Incase of any abnormal result, you may be asked to take further checks.
- 各種ワクチン接種歴，検査結果のコピー (母国語記載の場合は英語訳必要) を添付すること．異常を認めた場合は精密検査を要求することがあります．

This is to certify the information regarding infection control as stated above.

Doctor's Name: John Smith

Date: 6/26/2018

Signature: John Smith

Name of Hospital: Vietnam National Medical Center

Address: 12 Phan Phu Doan Street, Hoan Kiem District, Hanoi, Vietnam

Certificate of Infection Control

実習用 Form1

Name:

Name of company/ University:

Date of birth (M/D/Y):

Age:

Sex:

		Vaccination*	Date (M/D/Y)
4 Pediatric Viral Infections	**Measles** 麻疹	Dose 1	/ /
		Dose 2	/ /
	Mumps ムンプス	Dose 1	/ /
		Dose 2	/ /
	Rubella 風疹	Dose 1	/ /
		Dose 2	/ /
	Varicella (Chickenpox) 水痘	Dose 1	/ /
		Dose 2	/ /

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	Blood test **	Date (M/D/Y)	Result **Submission of a copy of test result is required.**
Hepatitis B B型肝炎 NOTE: Please fill **EITHER** "blood test" or "vaccination record".	HBs Ab	/ /	☐ Positive (10≧mlU/ml) / ☐ Negative
	Vaccination *	**Date (M/D/Y)**	
	Dose 1	/ /	
	Dose 2	/ /	
	Dose 3	/ /	

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	History of infection 感染歴		
Tuberculosis 結核		☐ No / ☐ Yes (Month and Year: /)	
	IGRA test **	**Date (M/D/Y)**	**Result** ****Submittion of a copy of test result is required.**
		/ /	☐ Positive / ☐ Negative / ☐ Indeterminate 判定保留
	Method of testing	☐ QuantiFERON-TB / ☐ T-SPOT.TB	

	Vaccination	Date (M/D/Y)	
Influenza インフルエンザ		/ /	NOTE: Only visitors from Oct. 1st ~ the end of Feb. are required. ☐ Visiting period doesn't include Oct~Feb.

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This is to certify the information regarding infection control as stated above.

Doctor's Name:

Date: **(M/D/Y)**

Signature:

Name of Hospital:

Address: