STANFORD UNIVERSITY
OFFICE OF POSTDOCTORAL AFFAIRS

POSTDOCTORAL FELLOW PATIENT CARE INFORMATION SHEET

(Required for all MDs and all non-MDs with SHC patient contact; excludes Clinical Psychologists)

Name: Social Security #:

(Last, First Middle Initial)

Department/Division:

Specialty: Degree(s) Completed: ☐ MD ☐ PhD

Previous Institution: Graduation date: (mm/dd/yyyy)

List the insitution in which you received your MD and/or PhD degree

I confirm that I am credentialed to see patients at SHC for research and training purposes and also that the above referenced Postdoctoral Fellow will have:

☐ **No patient contact** during the fellowship at Stanford Hospital/Clinics **PI Initial:**

(Faculty Sponsor and Fellow must sign form. Do not complete any other portion of the Information Sheet.)

☐ **May have incidental patient contact** during his/her fellowship. **PI Initial:**

If patient contact only involves systematic investigation designed to develop or contribute to generalizable knowledge, check "No Patient Contact"and follow guidance at:

Medical Research: http://humansubjects.stanford.edu/research/medical/medical.html OR
Nonmedical Research: http://humansubjects.stanford.edu/research/nonmedical/nonmedical.html

☐ **Full patient care responsibilities** of a clinical fellow. **PI Initial:**

If full patient care, is this position an accredited fellowship: ☐ Yes, clinical year ☐ Yes, research year only ☐ No

If yes, please indicate the type of accreditation: ☐ ACGME ☐ ABMS ☐ Other

Will a request for billing privileges be submitted for the above referenced Postdoctoral Fellow? ☐ Yes ☐ No

If yes, attach the Agreement for Services Outside the Fellowship and include the "billing paragraph" in offer letter. Please note, Stanford does not allow ACGME fellows to bill for services. For fellows in "non-approved" programs, billing is restricted to services not in their areas of training.

California Medical License #: Expiration Date:

Attach a copy of the Medical School diploma and a copy of the California Medical License showing the expiration date. For international medical school graduates, please also include a copy of the ECFMG certificate.

Postgraduate Year: ☐ I ☐ II ☐ III ☐ IV ☐ V ☐ Other

Previous Training (List Speciality & Location):

PGY I Dates:

PGY II Dates:

PGY III Dates:

PGY IV Dates:

PGY V Dates:

Postdoctoral Fellow Signature: Date:

Faculty Sponsor Name: Title:

Faculty Sponsor Signature: Date:

Program Director Name: Title:

Program Director Signature: Date:

[Office of Postdoctoral Affairs use only]

Term of appointment: _____ Date faxed: _____ Initial: _____

Submit original copy to the Office of Postdoctoral Affairs (OPA). Maintain copy for department files.

Print Form

POSTDOCTORAL IMMUNIZATION REQUIREMENTS*

*Prices current as of 4/8/08. Please check the Vaden Health Center for the most updated pricing list.

Tetanus and Diphtheria Immunity	
Provide the following information: • Date of adult tetanus and diphtheria (Td) immunization within the past 10 years If you have not had a Td immunization in the past 10 years, you will need to do so now	Cost at Vaden Health Center for: • Td Immunization -- $55.00
Measles Immunity (Rubeola)	
If you were born after 1956, provide the following information: • Date of measles vaccinations (two doses) or dates of two of combined measles, mumps, and rubella vaccination **-OR-** • Date and physician's signature of physician diagnosed measles **-OR-** • Date and titer results of serology confirming immunity	Cost at Vaden Health Center for: • MMR Immunization -- $63.00 • Measles Titer -- $32.10
Mumps Immunity	
Provide the following information: • Date of mumps vaccination (two doses) or dates of two combined measles, mumps, and rubella vaccination **-OR-** • Date of history of disease **-OR-** • Date and titer results of serology confirming immunity If you have not obtained either of these, you will need to do so now	Cost at Vaden Health Center for: • MMR Immunization -- $63.00 • Mumps Titer -- $19.30
Rubella Immunity (German measles)	
Provide the following information: • Date of rubella vaccination after 1969 (one rubella or date of one combined measles, mumps, and rubella vaccination) **-OR-** • Date and titer results of serology confirming immunity If you have not obtained either of these, you will need to do so now	Cost at Vaden Health Center for: • MMR Immunization -- $63.00 • Rubella Titer -- $22.85
Varicella Immunity (Chicken Pox)	
Provide the following information: • Date of varicella vaccinations (two doses) **-OR-** • Date and titer results of serology--must have M.D. signature If you have not obtained either of these, you will need to do so now	Cost at Vaden Health Center for: • Varicella Immunization -- $85.00 • VaricellaTiter -- $30.60
Hepatitis B Immunity	
Provide the following information: • Dates of three immunization, followed by • Date and titer results of serology--must have M.D. signature Note: It takes seven months to complete this immunization requirement	Cost at Vaden Health Center for: • Hepatitis B Immunization -- $42.00 • Hepatitis B Titer -- $32.70
Tuberculosis (TB) Testing	***Test must be repeated annually**
Provide the following information: • Date, type of test, and result of most recent TB test (result must be in millimeters) • If your test results were positive (reaction of 10 millimeters or greater) or if you have ever been treated for Tuberculosis, a repeat test is not necessary. However, you must provide the date and result of your diagnostic X-ray and include a copy of the X-ray report. The X-ray must have been done in the US or Canada only. No other countries are acceptable.	Cost at Vaden Health Center for: • TB test -- $19.00 • Chest X-ray -- $75.00
Influenza Immunity	***Immunization must be repeated annually**
Provide the following information: • Dates of last flu shot (within the last twelve months)	Cost at Vaden Health Center for: • Flu Shot Immunization -- $22.00

IMMUNIZATION RECORD
SCHOOL OF MEDICINE POSTDOCTORAL FELLOWS WITH PATIENT CONTACT

If you do not obtain the required immunications, you may be placed on Medical Hold, which will prevent disbursement of your stipend/fellowship support and access to campus facilities.

Note: If you do not obtain the below immunizations before arriving at Stanford, they are available through COWELL STUDENT HEALTH for a fee. These fees are your responsibility except for the Hepatitis B vaccine series, which is paid by the Medical School for you.

Name: _____ Birthdate: _____
(Last, First Middle Initial)

VACCINE	DATE	COWELL USE ONLY
☐ **MEASLES, MUMPS, RUBELLA (MMR) twice,** **-OR-** ☐ **All of the below**	#1 ___/___/___ #2 ___/___/___	
MEASLES		
☐ 1. Two vaccinations **-OR-**	1. ___/___/___ ___/___/___	
☐ 2. Physician documented disease Signature of MD (required):_____ **-OR-**		
☐ 3. Laboratory evidence of disease immunity	3. ___/___/___	
MUMPS		
☐ 1. Vaccination **-OR-**	1. ___/___/___	
☐ 2. History of disease **-OR-**	2. ___/___/___	
☐ 3. Laboratory evidence of disease immunity	3. ___/___/___	
RUBELLA		
☐ 1. Vaccination **-OR-**	1. ___/___/___	
☐ 2. Laboratory evidence of disease immunity	2. ___/___/___	
VARICELLA (Chicken pox)		
☐ 1. Two vaccinations **-OR-** ☐ 2. Laboratory evidence of disease immunity Signature of MD (required): _____	1. ___/___/___ ___/___/___ 2. ___/___/___	
HEPATITIS B		
1. Three (3) Hepatitis B vaccinations **-AND-** 2. Documentation of positive antibody to Hepatitis B Signature of MD (required): _____	1. ___/___/___ ___/___/___ ___/___/___	
TUBERCULOSIS screening (yearly)		
☐ 1. Tb skin test ☐ Type ☐ Result **-OR-** ☐ 2. Chest X-Ray result ☐ Result **-OR-** ☐ 3. Chest X-Ray brought from home country	1. ___/___/___ 2. ___/___/___ 3. ___/___/___	

Date	Signature of Person Providing Above Information

Return completed and signed form to the Office of Postdoctoral Affairs