Letters to the Editor

A Varicella-zoster Immunization Certification Form for Hospital Employees

To the Editor:

Our experience(s) with varicella-zoster virus exposures closely resembles those described by Krasinski et al (*Infect Control* 1986; 7:312-316). Contrary to their experiences, two of our susceptible furloughed personnel did develop varicella. This may have been unfortunate for the individuals involved, but it helped our Infection Control Team demonstrate to Administration that our hectic and expensive epidemiologic efforts are well worthwhile.

We would like to share a partial solution with your readers. Printed below is a form which was developed after 4 years of the same frenzy and frustrations as those described in the article. The form provides us with prospective knowledge of the immune/susceptible status of employees, including house officers and all students affiliated with Winthrop-University Hospital. The requirement has met with objections and resistance and the usual "no one else does this!" comment. But with Administration firmly committed to our effort, we insist on compliance. We include non-hospital employed personnel who service equipment or have other access to patient areas, ie, hemodialysis machines, TV rentals, etc, and this procedure has already proved its worth several times.

Inge Gurevich, RN, MA, CIC
Coordinator, Infection Control Program
Winthrop-University Hospital
Mineola, New York

IMMUNIZATION CERTIFICATION

Employee Health Service
Winthrop-University Hospital
259 First Street
Mineola, LI, NY 11501

Name _____ Employer: _____

Occupation: _____

Please Print

The following information is required before you can begin your rotation at Winthrop-University Hospital. Please return the completed form to the Employee Health Service.

1. **Rubella Titer:** _____
   Vaccination Date: _____
   If titer is less than 1:8, rubella immunization certificate is required.

2. **PPD Tuberculin Skin Test:**
   Date: _____
   mm of Induration: _____
   PPD is required every 2 years for all negative reactors.

3. **Chest x-ray if more than 10 mm induration:**
   Date: _____
   Result: _____

4. **Childhood Diseases** (vaccine or disease)

	Chicken Pox	Measles	Mumps
Positive			
Negative			
Unknown			

Authorized clinic physician or personal physician:

Name: _____ **Date:** _____
Please Print

Signature: _____