Medical Certificate for Trainees at the Medical Center of the University of Munich

This form has to be completely filled in and signed by the trainee´s attending physician and sent to the occupational health service at least two weeks before start of internship.

Assignment as ____ Medical Student at a university abroad _____

Department _____

This is to certify that ………………………………………………………………., born on………………………… is physically and mentally healthy and does not suffer from infectious diseases. There are no medical concerns regarding the intended internship.

Immunities concerning Measles, Chicken pox and Whooping cough are compulsory for every trainee. Exception: "career day without active participation":

Measles:

- O trainee obtained at least two vaccinations   *or*
- O positive serologic testing for measles immunity

Chicken pox:

- O confirmed chicken pox disease in trainee`s medical history   *or*
- O trainee obtained at least two vaccinations   *or*
- O positive serologic testing for chicken pox immunity

Whooping cough:

- O trainee obtained the last vaccination on _____ (date) (within last 9 years)

Hepatitis B and C: If nursing/medical/dental/assistance tasks will be performed on patients, please confirm additionally:

- O infectious hepatitis B is currently ruled out   (complete basic hepatitis B immunisation + antiHBs >100 U/l documented **or** HBs-AG negative, result originating within 3 months prior to start of internship)
- O infectious hepatitis C is currently ruled out (antiHCV negative. result originating within 3 months prior to start of internship)

HIV: If invasive/surgical tasks will be performed on patients, please confirm additionally:

- O HIV infection is currently ruled out (result originating within 3 months prior to start of internship)

Hepatitis A: If preparation of food/cooking tasks in canteens or shared kitchens will be performed, please confirm additionally:

- O trainee obtained at least two vaccinations   *or*
- O positive serologic testing of immunisation

By my signature, I confirm the accuracy of the statements above

_____
place / date / signature of the physician

readable seal with physicians name