

Clinical Nutrition Internship & Residency Program  
The University of Memphis  
Hepatitis B Form #1

Student Name \_\_\_\_\_ Date \_\_\_\_\_

Hepatitis B Vaccine

To complete requirements for admission to the Dietetic Internship, Hepatitis B immunizations and a titer are mandatory for University of Memphis Dietetic Internship students. Any student who has previously taken these immunizations should provide documented evidence for their file that the series and titer have been completed. Such documentation can be attached to these forms.

The first two immunizations must be taken prior to the start of the fall semester. These immunizations should be taken 30 days apart.

Date of 1<sup>st</sup> \_\_\_\_\_ Provider's Signature \_\_\_\_\_

Date of 2<sup>nd</sup> \_\_\_\_\_ Provider's Signature \_\_\_\_\_

Submit a copy documenting the first two injections at orientation in August.

Clinical Nutrition Internship & Residency Program  
The University of Memphis  
Hepatitis B Form #2

Student Name \_\_\_\_\_ Date \_\_\_\_\_

Hepatitis B Vaccine

To complete requirements for admission to the Dietetic Internship, Hepatitis B immunizations are mandatory for University of Memphis Dietetic Internship students. Any student who has previously taken these immunizations should provide documented evidence for their file that the series has been completed.

The third immunization must be taken prior to the start of the spring semester.

Date of 3<sup>rd</sup> \_\_\_\_\_ Provider's Signature \_\_\_\_\_

The post-vaccination titer should be taken 30 days after the 3<sup>rd</sup> immunization. It must be taken by March 15<sup>th</sup> of the spring semester.

Date of Titer \_\_\_\_\_ Results \_\_\_\_\_

Provider's Signature \_\_\_\_\_

Submit this completed form by March 15<sup>th</sup> for your student file.

Clinical Nutrition Internship & Residency Program  
The University of Memphis  
Physical Examination Form

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ Pulse: \_\_\_\_\_

I, find the patient, \_\_\_\_\_ to be in good health and free of communicable diseases.

Tuberculin Skin Test (within one year of the fall semester).

Date: \_\_\_\_\_

Results: \_\_\_\_\_

Any physical limitations: \_\_\_\_\_ No \_\_\_\_\_ Yes (explain) \_\_\_\_\_

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Any chronic illness: \_\_\_\_\_ No \_\_\_\_\_ Yes (explain) \_\_\_\_\_

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Provider's Name (please print) \_\_\_\_\_

Provider's Signature \_\_\_\_\_ Date of Examination \_\_\_\_\_

Submit this completed form at orientation in August.