



**DIAGNOSTEMPS**  
RADIOLOGY STAFFING

**Varicella Disclaimer**

**Name** \_\_\_\_\_  
*Please Print*

**Title** \_\_\_\_\_

**Social Security** \_\_\_\_\_

Please check one of the following:

- I have had Chickenpox as a Child Adult  
(Please Circle)  
Validating documents are are not attached.  
(Please Circle)
- I received the varicella immunization on \_\_\_\_\_.  
Validating documents are are not attached.  
(Please Circle)
- I have had a titre done and results indicate immunity.  
Validating documents are are not attached.  
(Please Circle)
- I have never had chickenpox or the varicella vaccine.

\_\_\_\_\_  
Technologist

\_\_\_\_\_  
Date

\_\_\_\_\_  
DiagnosTemps

\_\_\_\_\_  
Date