

Hepatitis B Vaccination Information

Any person who performs tasks involving contact with blood, blood-contaminated body fluids, other body fluids, or sharps should be vaccinated against Hepatitis B. The risk of contracting Hepatitis B is as high as 30 percent. The Hepatitis B vaccine is an effective and safe way of protecting yourself from this infection. The vaccine consists of a series of three injections given over a six-month period. The complete series is over 85% effective for at least nine years. If you have received the vaccination series your immunity status can be determined through antibody testing.

Name: _____

Provide us with your VACCINATION History - or - complete the WAIVER section

Vaccination History:

I, _____, have completed the Hepatitis B vaccine series. I am immune, or I am in the process of receiving the vaccine. (Circle one or complete waiver section).

- Please fill in below.
- Documentation or serology report from physician/QHP must be attached to validate this information.

Series 1 _____ Date Given: _____

Series 2 _____ Date Given: _____

Series 3 _____ Date Given: _____

Titre (Date & Result): _____

Waiver:

I, _____, understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B virus (HBV) infection.

I have been given the opportunity to be vaccinated with Hepatitis B Vaccine, at no charge to myself. However, I decline the Hepatitis B Vaccine at this time.

I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease.

If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series at no charge to me.

By signing below I acknowledge that I have received/read the information and have completed the Vaccination information and provided appropriate documentation and/or have completed the waiver section.

Employee's Signature

Date

Supplemental Health Care Signature

Date