**Associate/Workforce Member Hepatitis B Vaccine Form**

***Please print legibly.***

**Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of hire: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Job Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Supervisor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please check the risk category associated with your position:**

|  |  |  |
| --- | --- | --- |
| * **Category I—High Risk: Routinely at risk for exposure.** * Physicians * Physicians Assistants * Nurse Practitioners * Nurses * Medical Assistants * Dentists * Dental Assistants * Laboratory * Technicians/Assistants * Dental Hygienist * Therapist * Radiology * Transportation | * **Category II—Moderate Risk: Not routinely at risk for exposure. However, the potential for exposure may occur during an emergency.** * Maintenance/Housekeeping * Security * Behavioral Health Clinical Staff * Residential Facility * Patient Registration staff (PSR) * CSS workers | * **Category III—Low Risk:**   **Not at risk of exposure as part of usual duties.**   * Administration staff * Business Office * Materials Management * Pharmacy staff * Clerical staff * Information Technology * Call Center * Finance * Human Resources |

**(Please check one)**

* I have previously received the complete Hepatitis B vaccination series.
* Antibody testing has revealed I am immune to Hepatitis B. *(Please submit laboratory numerical proof of immunity.)*
* The vaccine is contraindicated for medical reason(s): (Please describe)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Other, explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please turn over and consent or decline the hepatitis B vaccine.**

**Signing this form is mandatory for any Associate in Category I and II.**

**Category I & II Associates:**

* **CONSENT:** I understand that due to my potential for occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been informed about, and offered the opportunity to receive, the Hepatitis B vaccine (to be paid for by Swope Health Services). I understand that I must have 3 doses of vaccine to develop immunity. However, as with any medical treatment, there is no guarantee that I will become immune or that I will not experience any adverse side effect from the vaccine. **I accept the offer at this time.**
* **DECLINATION:** I understand that due to my potential for 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 Hepatitis B vaccination at this time. I know this continues to put me at risk, but 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 it at no charge to me.  **I am declining the opportunity to receive the Hepatitis B vaccination series for the following reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**The above information is true and accurate to the best of my knowledge.**

**SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SECTION BELOW TO BE COMPLETED ONLY BY PERSON ADMINISTERING THE VACCINATION**

**Dose #1**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| ***Type of Vaccine*** | ***Date*** | ***Dose*** | ***Site*** | ***Manufacturer*** | ***Lot*** | ***Expiration***  ***Date*** | **Signature & Title of Vaccine Administrator** |
| **Hepatitis B**  **(give IM)** |  | IM | Left Deltoid  Right Deltoid |  |  |  |  |
| **Physician signature for Hepatitis B vaccine is for all doses to complete the series for full recommended immunization.** | | | | **Ordering Provider: xxxxxxxxxxxxxxxxxx** | | | | |

**Dose #2**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| ***Type of Vaccine*** | ***Date*** | ***Dose*** | ***Site*** | ***Manufacturer*** | ***Lot*** | ***Expiration***  ***Date*** | **Signature & Title of Vaccine Administrator** |
| **Hepatitis B**  **(give IM)** |  | IM | Left Deltoid  Right Deltoid |  |  |  |  |

**Dose #3**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| ***Type of Vaccine*** | ***Date*** | ***Dose*** | ***Site*** | ***Manufacturer*** | ***Lot*** | ***Expiration***  ***Date*** | **Signature & Title of Vaccine Administrator** |
| **Hepatitis B**  **(give IM)** |  | IM | Left Deltoid  Right Deltoid |  |  |  |  |