HEPATITIS B FORM

As an employee having occupational exposure to potentially infectious materials, you will have the right to receive the Hepatitis B vaccination series, free of charge to you. Please read the Hepatitis B Vaccination information sheet and complete his form by checking the box preceding the appropriate statement and signing, dating, and indicating your social security number a the bottom.

☐ **1. CONSENT TO GET VACCINATED:** As a healthcare professional having occupational exposure to blood or other potentially infectious materials, which includes the 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 my current employer). 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.

☐ **2. DECLINE TO GET VACCINATED**: 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 (HVB) 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 understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future, while actively working with CoreMedical Group, if 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.

☐ **3. DECLINE TO GET VACCINATED FOR SPECIFIC REASON**: I am declining the opportunity to receive the Hepatitis B vaccination series for the following reason (please check one):

- **a. I have previously received the complete Hepatitis B vaccination series (PLEASE NOTE: MUST SUPPLY COPY OF SERIES TO COREMEDICAL GROUP IF YOU CHECK THIS BOX)**
- **b. Antibody (TITER) testing has revealed I am immune to Hepatitis B (PLEASE NOTE: MUST SUPPLY COPY OF TITER TO COREMEDICAL GROUP IF YOU CHECK THIS BOX)**
  Date Tested _____
- **c. The vaccine is contraindicated for medical reason, describe:** _____

  _____
- **d. Other, explain:** _____

_____ _____

Employee Signature **Date**

_____

Print Employee Name

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