

## HEPATITIS B VACCINATION CONSENT/DECLINATION

As an employee having occupation exposure to potentially infectious materials, you will have the right to receive the Hepatitis B vaccination series, free of cost to you. Please read the Hepatitis B Vaccination information sheet and complete this form by checking the box preceding the appropriate statement and signing, dating and indicating your Social Security Number at the bottom. Upon completion, please return document to MedStaff. Thank you!

infecti inforn emplo medic	<b>SENT:</b> As a healthcare professional having occupational exposure to blood or other potential tious materials, which includes the risk of acquiring Hepatitis B virus (HBV) infection, I have been med about and offered the opportunity to receive the Hepatitis B vaccine (to be paid for by my current oyer). I understand that I must have 3 doses of vaccine to develop immunity. However, as with any cal treatment, there is no guarantee that I will become immune or that I will not experience any rse side effect from the vaccine. I accept the offer at this time.	
Signat	ture:	Date:
<b>DECLINATION (General):</b> 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 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 MedStaff, 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.		
Signat	ture:	Date:
	<b>INATION (Specific):</b> I am declining the opportunity to receive the Hepa llowing reason: (please check one)	atitis B vaccination series for
	I have previously received the complete Hepatitis B vaccination series. complete the Vaccination Record of our Physical form).	(Please have your physician
	Antibody testing has revealed I am immune to Hepatitis B. (Please sub	mit proof of immunity.)
	The vaccine is contraindicated for medical reason, describe:	
	Other, explain:	
Signat	ture:	Date: