HEPATITIS B VACCINATION VERIFICATION

Employee Name _____

Social Security Number ☐☐☐-☐☐-☐☐☐☐

Initial Date of Employment ☐☐ -☐☐-☐☐

HBV Series (Requires three injections)

1st _____ 2nd _____ 3rd _____
(date) (date) (date)

Date of Booster (if necessary, live vaccination requires a booster) _____

Reason for medical contra-indication _____
_____
_____

_____ _____
Employee Signature Date

This form is to be maintained by the employer for at least the length of employment plus 30 years.
This form and attached records are confidential. We will not disclose any facts without expressed written consent of employee or employee representative.

Hepatitis B Vaccination Waiver

I understand that, due to my occupational exposure to blood or potential infectious material, I may be at risk of acquiring the Hepatitis B virus (HBV) infection. 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.

_____ _____
Employee Signature Date