

## Hepatitis B Vaccination Consent/Declination

As an employee having occupational 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 the Company. Thank you!

- CONSENT:** 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.
- DECLINATION:** 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 know this continues to put me at risk, but if in the future, while actively working with the Company, 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 vaccine for the following reason(s):  
(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:

Signature: \_\_\_\_\_

SSN: \_\_\_\_\_