

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 Specialty Professional Services, Corp. Thank you!

CONSENT: As a healthcare professional having occupational exposure to blood or other potential 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.

Signature: _____ Date: _____

DECLINATION (General): 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 Specialty Professional Services, Corp, 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.

Signature: _____ Date: _____

DECLINATION (Specific): I am declining the opportunity to receive the Hepatitis B vaccination series for the following reason: (please check one)

I have previously received the complete Hepatitis B vaccination series. (Please have your physician complete the Vaccination Record of our Physical form).

Antibody testing has revealed I am immune to Hepatitis B. (Please submit proof of immunity.)

The vaccine is contraindicated for medical reason, describe:

Other, explain: _____

Date: _____

Employee Signature:

Employee Name (Please Print):

Employee Social Security Number: