THE OKLAHOMA STATE UNIVERSITY CENTER FOR HEALTH SCIENCES
Hepatitis B Virus Vaccination Information

EMPLOYEE NAME: _____

EMPLOYEE TITLE: _____

EMPLOYEE DEPARTMENT: _____

Within the scope of your responsibilities as an employee of The Oklahoma State University Center for Health Sciences, you may be exposed to human body fluids or other potentially infectious materials which could pose a risk of acquiring hepatitis B virus (HBV) infection.

The College will provide the opportunity to be vaccinated with hepatitis B vaccine at no charge. Please indicate below whether you wish to accept or decline the offer of the vaccine.

_____ No, I decline the hepatitis B vaccination for one of the following reasons:

_____ I have previously received the complete hepatitis B vaccination.

_____ Antibody testing shows that I am immune.

_____ I cannot receive the vaccine for medical reasons.

_____ 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 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 the vaccination series at no charge to me.

_____ Yes, I wish to have the hepatitis B vaccine as soon as possible. I have had the opportunity to ask questions about hepatitis B and the hepatitis B vaccine. I have all the information I desire, and I understand the benefits and risks of hepatitis B vaccination. I understand that I must have three doses for the vaccine to be fully effective. I realize there is no guarantee that a person vaccinated will become immune, and I understand that adverse side effects may be experienced. I request that three doses of the vaccine be given to me.

_____ _____
(Employee's Signature) (Date)

Employee: Return copy of form to Supervisor after completion of above information.
Supervisor: If yes, schedule employee for requested vaccination with OSU-CHS Health Care Center, 2345 SWB, 918-582-1980; send this completed form with employee.

Dates Vaccinated	Mfg. & Lot No.	Physician's Signature
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Vaccination Provider: retain record upon completion of this form, with a copy given to employee