Appendix A. Hepatitis B Vaccination Acceptance/Declination Form

I, (please print name) ______________________________, understand that Pacific Lutheran University will make available to me, at no cost to myself, a series of injections to prevent me from becoming infected with hepatitis B virus. I know that the hepatitis B virus is a very serious, potentially life-threatening illness. Because of my occupational exposure to blood and/or body fluids during my working hours, I understand that I am at increased risk for hepatitis B infection.
Please check one:

- ☐ I have chosen to receive the hepatitis B recombinant vaccine series.
- ☐ I have chosen to decline the hepatitis B vaccine series at this time. 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. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious liver damaging disease. If in the future, I continue to have occupational exposure to blood or other potentially infectious materials at PLU and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.
- ☐ I have previously received the hepatitis B vaccine series. Dates of vaccination:

I also acknowledge that I have received training
I understand the procedures instituted by PLU to protect me from such hazards and my right to be afforded such protection.

____

Employee Name (print) Employee Signature

____

Social Security Number Date

____

Trainer's Signature Title

Appendix B. Health Care Providers Written Opinion for Hepatitis B Vaccination

Employee's Name: ______________________________

Date of Evaluation: ______________________________

Health Provider's Address: ______________________________

____

Health Provider's Telephone ______________________________

As required by the Occupational Exposure to Bloodborne Pathogens rule, Chapter 296-823 WAC:

Hepatitis B vaccination **is** ____ **is not** ____ recommended for the employee named above.

The employee named above is scheduled to receive 3 total hepatitis B vaccinations on the following dates:

1st of 3 ______________________

2nd of 3 ______________________

3rd of 3 ______________________

____

Healthcare Provider signature

______________________ ______________________

Healthcare Provider signature Date

Return this form to the employer, and provide a copy to the employee, within 15 days. Please label the outside of the envelope "Confidential."

Employer Name ______________________

Address ______________________

____

Confidential fax ______________________

Appendix C. Health Care Provider's Written Opinion for Post Exposure Evaluation

Employee's Name: ______________________________

Date of Incident: ______________________________

Date of Evaluation: ______________________________

Health Professional's Address: ______________________________

____

Health Professional's Telephone: ______________________________

____ The employee named above has been informed of the results of the evaluation for exposure to blood or other potentially infectious materials.

____ The employee named above has been told about any health conditions resulting from exposure to blood or other potentially infectious materials that require further evaluation or treatment.

____ Hepatitis B vaccination **is**____ **is not**____ indicated.

____
Health Care Professional's Name

______________________________ ______________________
Health Care Professional's Signature Date

Return this form to the employer and provide a copy to the employee within 15 days. Please label the outside of the envelope "Confidential."

Employer's Name ______________________________

Employer's Address: ______________________________

____

Confidential Fax: ______________________________