



## HEPATITIS B VACCINATION PROGRAM MEDICAL REPORT

NAME: \_\_\_\_\_ Employee ID No: \_\_\_\_\_

FUNCTIONAL UNIT: \_\_\_\_\_

### HEPATITIS B VACCINATION STATUS

1<sup>st</sup> Vaccination Date: \_\_\_\_\_ Signature: \_\_\_\_\_  
Lot #: \_\_\_\_\_ Licensed Healthcare Professional

2<sup>nd</sup> Vaccination Date: \_\_\_\_\_ Signature: \_\_\_\_\_  
Lot #: \_\_\_\_\_ Licensed Healthcare Professional

3<sup>rd</sup> Vaccination Date: \_\_\_\_\_ Signature: \_\_\_\_\_  
Lot #: \_\_\_\_\_ Licensed Healthcare Professional

Declination Form Received, Signed, and Dated: \_\_\_\_\_

### LICENSED HEALTHCARE PROFESSIONAL'S WRITTEN OPINION

1. Hepatitis B Vaccination Date: \_\_\_\_\_

- Is indicated
- Is not indicated
- Employee has received vaccination

Signature: \_\_\_\_\_  
Licensed Healthcare Professional

2. Post-Exposure Evaluation/Follow-Up Date: \_\_\_\_\_

- Employee has been informed of results of evaluation.
- Employee has been told about any medical conditions resulting from exposure, which may require further evaluation and treatment.

Signature: \_\_\_\_\_  
Licensed Healthcare Professional