HEPATITIS B VACCINATION PROGRAM
MEDICAL REPORT

NAME: ___________________________ Employee ID No: _______________________

FUNCTIONAL UNIT: __________________________________________________________

HEPATITIS B VACCINATION STATUS

1st Vaccination Date: ____________ Signature: _________________________________
Lot #: _________________ Licensed Healthcare Professional

2nd Vaccination Date: ____________ Signature: _________________________________
Lot #: _________________ Licensed Healthcare Professional

3rd 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