**Hepatitis B Form **

Please complete one of the following statements.

**Waiver for Hepatitis B Vaccination**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring a Hepatitis B Virus (HBV) infection. I have been given the opportunity to be vaccinated 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 for other potentially infectious materials, and I want to be vaccinated with the hepatitis B vaccine, I can receive the vaccination series at no charge to me.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Department: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Request for Hepatitis B Vaccination**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that I may receive a Hepatitis B vaccines as part of ASC’s program to protect workers potentially exposed to blood and other infectious materials. I will make an appointment with my family physician and notify the Human Resources Department of the date and time. I will be compensation for 30 minutes for each time I receive the shot.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Department: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please return this form to the HR Office.