

**Employee’s Name: (please print)**

**Department:**

**Supervisor:**

**TU ID #:**

**Phone #:**

**Hepatitis B Vaccination Record:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **DOSE** | **DATE** |  **ARM (Deltoid)** | **Vaccine****Lot # /Exp. Date** | **Provider or Practice** |  **RN/MA Signature** |
| **1** |  | L / R |  |  |  |
| **2** |  | L / R |  |  |  |
| **3** |  | L / R |  |  |  |

**Hepatitis B Titer Record:**

|  |  |  |  |
| --- | --- | --- | --- |
| **RESULT** | **DATE** | **Name of Provider or Practice** | **RN/MA Signature** |
|  |  |  |  |

**Is booster series recommended? ❒ Yes ❒ No**

**Hepatitis B Booster Record:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **DOSE** | **DATE** |  **ARM (Deltoid)** | **Vaccine****Lot # /Exp. Date** | **Provider or Practice** |  **RN/MA Signature** |
| **1** |  | L / R |  |  |  |
| **2** |  | L / R |  |  |  |
| **3** |  | L / R |  |  |  |

* **Vaccination is medically contraindicated:**

***I verify the above record is accurate to the best of my knowledge.***

**Physician’s Name or Authorized Representative:**

**(please print)**

**Signature: Date:**