Acadia Workforce, Inc

REQUEST TO RECEIVE HEPATITIS B VACCINE

I have completed blood borne pathogen training and have understood the information presented to me about hepatitis B virus and hepatitis B vaccine and have had the opportunity to ask questions My. Questions have been answered. I want to participate in hepatitis vaccination program I understand. This includes three (3) intramuscular injections over a six (6) month period. I understand that there is no guarantee that I will become immune to hepatitis B and that I might experience an adverse side effect as their result of the vaccination. Note: If you opt to receive the hepatitis B vaccine, you must report to the designated medical provider and or Clinical Staff Support, Inc and or Nursing Group, Inc via email within 10 working days of signing this form.

Employee Name: ____

Date of Birth: ___________________

Employee signature: ____ Date: _________________

1st Dose: __________________ ____________________________ _________________
Date Administered Administered by Title

____
Lot#/Sticker

2nd Dose: __________________ ____________________________ _________________
Date Administered Administered by Title

____
Lot#/Sticker

3rd Dose: __________________ ____________________________ _________________
Date Administered Administered by Title

____
Lot#/Sticker

Please complete and return via Fax to: 800-331-1531 Or

Mail to: Acadia Workforce, Inc
PO Box 446 Round Rock, Texas 78680-0446