

Dear Candidates/Employees/Students and Visiting Scholars,

Welcome to Boston University!

Completion of the following forms are required for all individuals who work with or in proximity to patients at Boston University. These forms are due by _____ **(No exceptions)**. This information will be submitted to and evaluated by the Boston University Occupational Health Center (BUOHC) to determine if you are adequately protected from certain infectious diseases you may encounter during your patient care activities. If necessary, BUOHC will work with you to determine any preventative steps, including updating immunizations, which may be necessary to protect your health. A medical provider at BUOHC will review your immunization records and notify you should you need to provide any other documentation or receive additional immunizations.

Lillian Alves, MA at the Boston University Occupational Health Clinic on the Charles River Campus is your contact for this program. Her contact information is: Phone 617-353-6630 Monday – Friday from 9:30-11:30am and 1:00-4:30pm.

Please send in your completed Immunization Form along with your supporting documentation for review and clearance. An incomplete or partially completed Immunization Form WILL NOT be accepted or reviewed.

All immunization records are to be translated to English upon submission for review.

Please submit all immunization requirements one week prior to your start date for review. If you are unable to provide this information by the due date please contact our office.

These are the following steps you will need to take to complete the attached forms:

Step 1: Immunization Form

- Print the Immunization Form included with this packet
 - Have the form completed and signed by your Healthcare Provider.
 - You should **also submit supporting immunization documentation** in addition to the Immunization form (i.e. pediatric records, quantitative lab results etc.).
 - Please note **all documents must be translated into English**; the American Consulate can assist with this process

Step 2: Respiratory Medical Evaluation Questionnaire

1. Complete the two-page Respiratory Medical Evaluation Questionnaire (included in this packet)
 - This is a required form
 - Complete all sections
 - If you answer **Yes** to any questions, please offer an explanation and indicate if condition has resolved on the form or separate sheet of paper.

Step 3: Submission of documentation and forms

2. Once all forms are completed and signed, please scan and email with your immunization records to:
ohcimmu@bu.edu

- **Please note all forms and supporting documents must be scanned together, forms sent separately will not be reviewed**

Note: If you have any questions or difficulties completing these forms, please contact Lillian Alves, MA at BUOHC by calling 617-353-6630.

Sincerely,

Ann M. Zaia, PhD, CNP, SM, MSN, MHA, CHS, CHE, COHN-S, FAAOHN
Director, Boston University Occupational Health Center

Mandatory Immunizations

Required Immunization Information

Please note: All titers must include a lab report with quantitative results and include lab reference ranges for values

1. **COVID-19 VACCINE(S):**

All healthcare personnel are recommended to get vaccinated against COVID-19. Any WHO approved vaccination series will be accepted and considered compliant. A medical and/or religious exemption can be provided upon request.

2. **MMR / MEASLES, MUMPS, RUBELLA VACCINE:**

It is recommended that all healthcare providers (HCP) be immune to measles, mumps, and rubella. Evidence of immunity in HCP includes documentation of 2 doses of MMR vaccine given at least 28 days apart or laboratory evidence (quantitative titer) of immunity.

3. **VARICELLA VACCINE (CHICKENPOX):**

It is recommended that all healthcare providers (HCP) be immune to varicella. Evidence of immunity in HCP includes documentation of 2 doses of varicella vaccine given at least 28 days apart or laboratory evidence (quantitative titer) of immunity.

4. **HEPATITIS B VACCINE:**

All staff with patient contact are required to provide **written documentation of having had 3 doses** (dates must include month/day/year and be signed by healthcare provider) of this vaccination OR, read the Centers for Disease Control and Prevention's Vaccine Information Statement and sign where indicated on the declination form to decline the vaccine (declination form included in this packet).

- a. **If you have written documentation of your hepatitis B vaccine**, you **MUST** also submit evidence of a quantitative, positive hepatitis B titer that was drawn at least 4-6 weeks or longer after the date of your 3rd hepatitis B vaccine dose (or if you have had booster doses, the date of the last booster dose).
 - I. Please note, if your hepatitis B titer is negative (<10 mIU/mL) you should receive a booster dose of the vaccine and have your titer re-drawn 4-6 weeks later.

- II. If you are considered a “non-responder” (negative titer after 6 doses) please provide evidence of a recent (within 30 days) hepatitis B surface antigen titer result (lab report).

- b. **If you are unable to locate your hepatitis B vaccination records and are declining the vaccination**, no titer is required or recommended as this a positive titer may be potentially misleading, as an anti-HBs ≥ 10 mIU/mL as a correlate of vaccine-induced protection has only been determined for persons who have completed an approved vaccination series.

(source: <https://www.cdc.gov/mmwr/preview/mmwrhtml/rr6210a1.htm>)

Read the VIS here: <https://www.cdc.gov/vaccines/hcp/vis/vis-statements/hep-b.pdf>

5. Tdap VACCINE:

Tdap (Tetanus/ Diphtheria/ Pertussis): Tdap = Adacel or Boostrix within the last 10 years (please note this vaccine is different than standard Td which is not acceptable as it is missing the pertussis component).

6. TUBERCULOSIS SCREENING:

Required for all staff with patient contact.

- a. You must complete the Healthcare Personnel (HCP) Baseline Individual TB Risk Assessment form and the Tuberculosis Review of Symptoms Form (attached).
- b. You must provide evidence of having had a negative tuberculosis screening **as noted below** completed within 3 months of entering Boston University, if no prior positive test. **Please submit results indicated below:**

- I. Interferon-Gamma Release Assay (IGRA) blood test (QuantiFERON®-TB Gold In-Tube test (QFT-GIT) or T-SPOT®.TB test (T-Spot)) – You must submit a copy of the lab report along with this form (Tuberculin Skin testing is no longer accepted unless it is evidence of a past positive result).

1. Please note, prior BCG vaccine does not disqualify you for tuberculosis testing. TB blood tests (IGRAs), unlike the TB skin test, are not affected by prior BCG vaccination and are not expected to give a false-positive result in people who have received BCG. TB blood tests are the preferred method of TB testing for people who have received the BCG vaccine.

- c. If past or newly positive skin test or IGRA please include documentation of positive test result and chest x-ray report (x-ray must have been done after diagnosis of positive TB test and must state that it was performed to rule out tuberculosis). If you have been counseled and/or treated for tuberculosis, please provide this documentation as well.

7. INFLUENZA (FLU) VACCINE:

- a. Seasonal influenza (Flu) vaccine or declination form is required for current influenza season (typically the season in the U.S. is September through the end of April). All Boston University individuals with direct patient contact (within 6 feet of patients) **are highly encouraged** to receive the vaccine if eligible for their protection and the protection of our patients.

FREQUENTLY ASKED QUESTIONS:

- **I have questions about completing my paperwork, who should I contact?**

You can contact Lillian Alves, MA; Monday-Friday from 9:30-11:30am and 1:00-4:30pm (EST) by phone at 617-353-6630. She will be able to assist with questions.

- **Do I need a COVID-19 vaccine?**

Boston University is requiring all faculty and staff to be vaccinated against COVID-19. Please indicate what vaccine you received and submit proof of your vaccination by including your CDC Vaccination Card.

- **Do I need to get a titer for MMR/Varicella (Chickenpox)?**

It is EITHER the vaccine/records or quantitative titer for MMR and Varicella. Titers are not required if you have had the appropriate immunizations or are choosing to waive (for Hep B only) the immunizations. The quantitative titers will substitute for the immunizations if you cannot prove prior immunization dates.

- **Do I need to get a titer for Hepatitis B?**

For Hepatitis B, both the vaccine/records **AND** quantitative titer are required for all staff with patient contact. A positive titer result **without** documentation of a complete vaccine series does not indicate sero-protection against hepatitis B, as an anti-HBs ≥ 10 mIU/mL result as a correlate of vaccine-induced protection has only been determined for persons who have completed an approved vaccination series.

You can choose to decline (for Hep B only) the immunizations by reading the Centers for Disease Control and Prevention's Vaccine Information Statement and signing where indicated on the attached declination form. If you are declining vaccination, no titer is required.

- **Do I need to get TB tested (QFT-GIT/T-Spot or IGRA)?**

TB testing is mandatory unless you have documented proof of a prior positive TB test (skin test or IGRA). If this is the case, you must submit a chest x-ray report for a positive skin test or IGRA result showing no evidence of tuberculosis. **Prior vaccination with BCG does not disqualify you from TB testing.**

- **Can I have a Physician's Assistant or Nurse Practitioner sign my Immunization Form?**

The form must be signed by a medical office, clinic, health department, school health official, or other authorized health official (MD, DO, NP, PA). They should use an official office stamp for name of clinic, address, and phone. If there is no stamp, then they need to the clinic name, address, phone in addition to their name, title and date clearly printed on the form along with their signature.

- **Am I able to come to Boston University Occupational Health if I need updated immunizations prior to my starting work with patients?**

Yes, you may be eligible to receive requirements that are identified as missing components. You **MUST** contact BU Occupational Health Clinic at 617-353-6630 to discuss your eligibility and timing of start date to see if you qualify for this service.

- **Do I have to have a doctor sign my Respirator form?**

No. Please complete your part of the form and send it in with your packet and the BU Occupational Health provider will sign off on the bottom where it says to be completed by examiner/reviewer.

- **I have questions about filling out the Respirator form.**

You can contact clinic staff by calling 617-353-6630 Monday-Friday between 9:30-11:30am and 1:00-4:30pm and we will guide you through the form. You are filling out the form for potential use of an N95 paper disposable negative pressure respirator that might be used during patient care activities.

- **Will I need a health assessment/physical?**

Some candidates may require a health assessment by a medical provider at BUOHC if they are determined to have increased risk with respirator use. If you are notified that you require an examination, these appointments can be scheduled prior to your start date. If you have questions about the health assessment, please contact BUOHC directly by calling 617-353-6630.

- **I have a hold on my clearance for immunizations, what do I do?**

Please contact our office by calling 617-353-6630 M-F from 9:30-11:30am and 1:00-4:30pm and we will try to help determine what needs to be done to assist you with your clearance.



Boston University Mandatory Immunization History

IMPORTANT! DO NOT DELAY! This COMPLETED form is required for work clearance. NO EXCEPTIONS!

Name: _____ **Date of Birth:** _____

Phone Number: _____ **BU ID:** _____

Required Immunizations **NOTE: ALL TITERS MUST HAVE LAB REPORT ATTACHED WITH QUANTITATIVE RESULTS**

Either immunizations or titers may be submitted as appropriate.

Titers not required if immunization completed	Month/Day/Year	Month/Day/Year	Month/Day/Year	Titer Date & Result
MMR (2 doses after 1st birthday or results of quantitative titer; must submit lab documentation in addition to noting titer result)			DO NOT WRITE HERE	Measles: Mumps: Rubella:
TDAP (Tetanus/Diphtheria/ Pertussis)		DO NOT WRITE HERE	DO NOT WRITE HERE	DO NOT WRITE HERE
Influenza Vaccine for current season		DO NOT WRITE HERE	DO NOT WRITE HERE	DO NOT WRITE HERE
Varicella (Chickenpox) (2 doses required or results of quantitative titer; must submit lab documentation in addition to noting titer result)			DO NOT WRITE HERE	
Hepatitis B (3 doses <i>and</i> positive quantitative titer OR sign waiver below)				Quantitative titer result (must attach lab report): Note: Titer alone is not acceptable, must include dates of 3 doses in addition to titer if submitting a positive titer
COVID-19 (Any WHO approved series; please include manufacturer of each dose)	(1 st dose)	(2 nd dose)	(3 rd dose)	DO NOT WRITE HERE

- ☐ I have read the information (<https://www.cdc.gov/vaccines/hcp/vis/vis-statements/hcp-b.pdf>) about Hepatitis B and decline receipt of this vaccine.
- ☐ I understand the risks of refusing the hepatitis B vaccine and have signed the declination form (attached).

Signature of Patient: _____ **Date:** _____

Tuberculosis Screening:

Interferon-Gamma Release Assay (QFT-GIT or T-Spot)	Date:	Result: If Past Positive attach counseling letter/treatment record	Submit copy of lab report
Chest X-ray (if positive IGRA blood test)	Date:	Result:	Submit copy of chest X-ray report

An authorized medical signature, printed name, clinic address and phone number must appear here or this form will not be approved.

Office Stamp Here	Medical Provider Signature	Date
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IMPORTANT! KEEP A COPY OF THIS PAGE AND ALL LAB REPORTS FOR YOUR RECORDS.

Name: _____

Date of Birth: _____

Phone Number: _____

BU ID: _____



Health Care Personnel (HCP) Baseline Individual TB Risk Assessment

HCP should be considered at increased risk for TB if any of the following statements are marked "Yes":

	Temporary or permanent residence of ≥ 1 month in a country with a high TB rate Any country other than the United States, Canada, Australia, New Zealand, and those in Northern Europe or Western Europe	YES ☐ NO ☐
OR		
	Current or planned immunosuppression, including human immunodeficiency virus (HIV) infection, organ transplant recipient, treatment with a TNF-alpha antagonist (e.g., infliximab, etanercept, or other), chronic steroids (equivalent of prednisone ≥ 15 mg/day for ≥ 1 month) or other immunosuppressive medication	YES ☐ NO ☐
OR		
	Close contact with someone who has had infectious TB disease since the last TB test	YES ☐ NO ☐

Abbreviations: HCP, health-care personnel; TB, tuberculosis; TNF, tumor necrosis factor.

Individual risk assessment information can be useful in interpreting TB test results (see Lewinschhn DM, Leonard MK, LoBue PA, et al. Official American Thoracic Society/Infectious Diseases Society of America/Centers for Disease Control and Prevention Clinical Practice Guidelines: Diagnosis of tuberculosis in adults and children. Clin Infect Dis 2017;64:111-5).

Adapted from: Risk assessment form developed by the California Department of Health, Tuberculosis Control Branch.

Sosa LE, Njie GJ, Lobato MN, et al. Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel: Recommendations from the National Tuberculosis Controllers Association and CDC, 2019. MMWR Morb Mortal Wkly Rep 2019;68:439-43. https://www.cdc.gov/mmwr/volumes/68/wr/mm6819a3.htm?s_cid=mm6819a3_w



Tuberculosis (TB) is caused by a bacterium called *Mycobacterium tuberculosis*. The bacteria usually attack the lungs, but TB bacteria can attack any part of the body such as the kidney, spine, and brain. Not everyone infected with TB bacteria becomes sick. As a result, two TB-related conditions exist: latent TB infection (LTBI) and TB disease. If not treated properly, TB disease can be fatal. TB bacteria are spread through the air from one person to another. The TB bacteria are put into the air when a person with TB disease of the lungs or throat coughs, speaks, or sings. People nearby may breathe in these bacteria and become infected. TB is a treatable disease.

If you have additional questions please go to: <https://www.cdc.gov/tb/topic/basics/default.htm> or call BU Occupational Health at 617-353-6630.

Signature of Patient: _____

Date: _____

Tuberculosis Review of Symptoms Form

Name: _____ Date of Birth: _____

Phone Number: _____ BU ID: _____

Please answer ALL three questions below:

1. I have had a past **POSITIVE TB Test** ☐ YES ☐ NO
If **YES**, what year _____? Provide documentation of **positive test** and **counseling** with this completed form.

2. I have been **treated** for Tuberculosis. ☐ YES ☐ NO
If **YES**, what year _____? Provide documentation of **treatment** with this completed form.

3. I currently am having symptoms of:

☐ Cough lasting more than 3 weeks	☐ YES	☐ NO
☐ Coughing or spitting up any blood	☐ YES	☐ NO
☐ Any unexplained weight loss	☐ YES	☐ NO
☐ Drenching night sweats or fever lasting longer than 3 weeks	☐ YES	☐ NO
☐ Any loss of appetite for longer than 2 weeks	☐ YES	☐ NO
☐ Prolonged fatigue lasting more than 3 weeks	☐ YES	☐ NO
☐ Chest pain	☐ YES	☐ NO

Tuberculosis review of symptoms is part of the screening process. This is required by Centers for Disease Control and all Departments of Public Health.

All answers I have provided are true and correct.

Signature of Patient: _____ Date: _____

Name: _____ Date: _____ BU ID #: _____

Age: _____ Sex: _____ Job Title: _____ Department: _____

OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

TO THE EMPLOYER

Answers to questions in Section 1, and to question 9 in section 2 of part A, do not require a medical examination. However, it does require that a Physician or Licensed Health Care Professional (PLHCP) review this questionnaire and answer any questions you may have concerning the questions asked in this questionnaire.

TO THE EMPLOYEE

Can you read? (Circle one) Yes No

Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

TO THE PHYSICIAN OF OTHER LICENSED HEALTH CARE PROFESSIONAL (PLHCP)

Review Part A Sections 1 and 2. When an employee answers YES to any of the questions in Section 2 and the questionnaire is not administered in conjunction with a physical examination, the employee needs to be considered for a follow-up physical examination with particular emphasis on those areas in which the employee answered YES. When an employee answers YES to any of the questions in Section 2 and this questionnaire is completed in conjunction with a physical examination, the physician will place particular emphasis upon those areas to which the employee answered YES. In either situation the PLHCP will complete the "PLHCP's Written Statement" and email to both the employee and employer **within 2 days** of reviewing this form.

PART A SECTION 1 (MANDATORY)

The following information must be provided by every employee who has been selected to use any type of respirator (please print).

1. Your height: _____ ft. _____ in.
2. Your weight: _____ lbs.
3. Your job title: _____
4. A cell phone number where you can be reached by the health care professional who will review this questionnaire (include area code): _____
5. The best time to phone you at this number is: _____ am/ _____ pm.
6. Has your employer told you how to contact the health care professional who will review this questionnaire? (circle one):
Yes No
7. Check the type of respirator you will use (you can check more than one category):
 - a. _____ N, R, or P disposable respirator (filter-mask, non-cartridge type only).
 - b. _____ Other type (for example, half - or full-facepiece type, powered - air purifying, supplied - air, self-contained breathing apparatus).
8. Have you worn a respirator (circle one): Yes No
If "Yes", what type(s): _____

PART A SECTION 2 (MANDATORY)

Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator. (please circle "Yes" or "No").

- 1.** Yes No **Do you currently smoke tobacco, or have you smoked tobacco in the last month?**
- 2.** **Have you ever had any of the following conditions?**
 - Yes No a. Seizures (fits)
 - Yes No b. Diabetes (sugar disease)
 - Yes No c. Allergic reactions that interfere with your breathing
 - Yes No d. Claustrophobia (fear of closed-in places)
 - Yes No e. Trouble smelling odors
- 3.** **Have you ever had any of the following pulmonary or lung problems?**
 - Yes No a. Asbestosis
 - Yes No b. Asthma
 - Yes No c. Chronic bronchitis
 - Yes No d. Emphysema
 - Yes No e. Pneumonia
 - Yes No f. Tuberculosis
 - Yes No g. Silicosis
 - Yes No h. Pneumothorax (collapsed lung)
 - Yes No i. Lung cancer
 - Yes No j. Broken ribs
 - Yes No k. Any chest injuries or surgeries
 - Yes No l. Any other lung problem that you've been told about
- 4.** **Do you currently have any of the following symptoms of pulmonary or lung disease?**
 - Yes No a. Shortness of breath
 - Yes No b. Shortness of breath when walking on level ground or walking up a slight hill or incline
 - Yes No c. Shortness of breath when walking with other people at an ordinary pace on level ground
 - Yes No d. Have to stop for breath when walking at your own pace on level ground
 - Yes No e. Shortness of breath when washing or dressing yourself
 - Yes No f. Shortness of breath that interferes with your job
 - Yes No g. Coughing that produces phlegm (thick sputum)
 - Yes No h. Coughing that wakes you early in the morning
 - Yes No i. Coughing that occurs mostly when you are lying down
 - Yes No j. Coughing up blood in the last month
 - Yes No k. Wheezing
 - Yes No l. Wheezing that interferes with your job
 - Yes No m. Chest pain when you breathe deeply
 - Yes No n. Any other symptoms that you think may be related to lung problems

5. Have you ever had any of the following cardiovascular or heart problems?

- | | | | |
|-----|----|----|---|
| Yes | No | a. | Heart attack |
| Yes | No | b. | Stroke |
| Yes | No | c. | Angina |
| Yes | No | d. | Heart failure |
| Yes | No | e. | Swelling in your legs or feet (not caused by walking) |
| Yes | No | f. | Heart arrhythmia |
| Yes | No | g. | High blood pressure |
| Yes | No | h. | Any other heart problem that you've been told about |

6. Have you ever had any of the following cardiovascular or heart symptoms?

- | | | | |
|-----|----|----|---|
| Yes | No | a. | Frequent pain or tightness in your chest |
| Yes | No | b. | Pain or tightness in your chest during physical activity |
| Yes | No | c. | Pain or tightness in your chest that interferes with your job |
| Yes | No | d. | In the past two years, have you noticed your heart skipping or missing a beat |
| Yes | No | e. | Heartburn or indigestion that is not related to eating |
| Yes | No | f. | Any other symptoms that you think might be related to heart or circulation problems |

7. Do you currently take medication for any of the following problems?

- | | | | |
|-----|----|----|----------------------------|
| Yes | No | a. | Breathing or lung problems |
| Yes | No | b. | Heart trouble |
| Yes | No | c. | Blood pressure |
| Yes | No | d. | Seizures (fits) |

**8. If you've used a respirator, have you ever had any of the following problems?
(If you've never used a respirator, check the following space and go to question 9)**

- | | | | |
|-----|----|----|---|
| Yes | No | a. | Eye irritation |
| Yes | No | b. | Skin allergies or rashes |
| Yes | No | c. | Anxiety |
| Yes | No | d. | General weakness or fatigue |
| Yes | No | e. | Any other problems that interfere with your use of a respirator |

9. Yes No Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire?

Questions 10 to 15 below must be answered **ONLY** by every employee who has been selected to use either a **full-facepiece respirator or self-contained breathing apparatus (SCBA)**. For employees who have been selected to use other types of respirators, answering these questions is voluntary.

10. Yes No Have you ever lost vision in either eye (temporarily or permanently)

11. Yes No Do you currently have any of the following vision problems?

- | | | | |
|-----|----|----|----------------------------------|
| Yes | No | a. | Wear contact lenses |
| Yes | No | b. | Wear glasses |
| Yes | No | c. | Color blindness |
| Yes | No | d. | Any other eye or vision problems |

12. Yes No Have you ever had an injury to your ears, including a broken ear drum?

13. Do you currently have any of the following hearing problems?

- | | | |
|--------|----|-----------------------------------|
| Yes No | a. | Difficulty hearing |
| Yes No | b. | Wear a hearing aide |
| Yes No | c. | Any other hearing or ear problems |

14. Have you ever had a back injury?

Yes No

15. Do you currently have any of the following musculoskeletal problems?

- | | | |
|--------|----|---|
| Yes No | a. | Weakness in any of your arms, hands, legs, or feet |
| Yes No | b. | Back pain |
| Yes No | c. | Difficulty fully moving your arms and legs |
| Yes No | d. | Pain or stiffness when you lean forward or backward at the waist |
| Yes No | e. | Difficulty fully moving your head up or down |
| Yes No | f. | Difficulty fully moving your head side to side |
| Yes No | g. | Difficulty bending at your knees |
| Yes No | h. | Difficulty squatting to the ground |
| Yes No | i. | Climbing a flight of stairs or a ladder carrying more than 25 lbs. |
| Yes No | j. | Any other muscle or skeletal problem that interferes with using a respirator. |

PLEASE ATTACH A SEPARATE SHEET OF PAPER EXPLAINING ALL RESPONSES WHERE YOU ANSWERED "YES"

By signing below I attest, that to the best of my knowledge, the answers contained in this document are accurate.

Employee signature: _____ **Date:** _____

Hepatitis B Vaccine Declination Form

The following statement of declination of the hepatitis B vaccine must be signed by an applicant/student/employee who:

- Chooses not to accept the hepatitis B vaccine.
- Has had appropriate training regarding hepatitis B, hepatitis B vaccination, the efficacy, safety, method of administration and benefits of vaccination, given free of charge to the employee (hepatitis B VIS can be viewed at this link:
<https://www.cdc.gov/vaccines/hcp/vis/vis-statements/hep-b.pdf>)

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to myself. However, I decline hepatitis B vaccination 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 or 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.

Note: This statement **is not a waiver**; employees can request and receive the hepatitis B vaccination at a later date if they remain occupationally at risk for hepatitis B.

Employee Signature: _____

Date: _____

Print Name: _____

BU ID: _____