COMMUNITY HEALTH Care

HEPATITIS B IMMUNIZATION STATEMENT/AGREEMENT

For the protection of our patients and staff, Community Health Care requires Hepatitis B immunization as a condition of employment for all employees who are involved in direct patient care. Sign the statement below that best reflects your Hepatitis B immunization status.

- **I have received** the Hepatitis B immunization series. I understand that I can request a titer to verify immunity.

  _____ _____
  Employee Signature Date

- **I have not received** the Hepatitis B immunization series. I will begin the series within one week of my employment.

  _____ _____
  Employee Signature Date

- **I Understand** that I cannot have this immunization if **I am pregnant.** Therefore, if I am now pregnant and cannot complete the immunization series, Community Health Care will attempt to place me in a non-patient contact position. If it is not possible to place me in a non-patient care position, I will be given the option to take pregnancy leave according to state/federal laws and agency policy.

  _____ _____
  Employee Signature Date

- **I Understand** that my current assignment is a position with **no direct patient care.** Therefore, I am not required to complete the Hepatitis B immunization series. Should my position or job duties change to include direct patient care, I will begin the series.

  _____ _____
  Employee Signature Date

- **I am declining** the Hepatitis B immunization series. **I Understand** that due to my occupational exposure to blood borne pathogens, I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to receive the Hepatitis B immunization series at no cost to myself. If I decide to receive the series, I will request it in writing to my supervisor.

  _____ _____
  Employee Signature Date