Biological Safety Program

Bloodborne Pathogens Program

Form

Hepatitis B Vaccination Record Form

Employee Name	
Department	TU ID #
Supervisor	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 Name or Authorized Representative (Please Print)	
Signature	**Date**