

**PROTECTIVE
HEALTH
SERVICES**

Oklahoma State Department of Health
Protective Health Services
Consumer Protection Division
1000 NE 10th Street
Oklahoma City, OK 73117-1299
Telephone: (405) 271-5243
FAX: (405) 271-3458

HEPATITIS B VACCINATION ACCEPT/DECLINE

Artist's Name: _____

Street Address: _____
City State Zip

Mailing Address (if different): _____

Telephone: _____ Date of Birth: ____/____/____ Sex: M ___ F ___

The employee named above is scheduled to receive the Hepatitis B vaccine on the following dates:

First Dose _____

Second Dose _____

Third Dose _____

Signature of healthcare provider: _____

Print name of healthcare provider: _____

Signature of Artist: _____

I understand that due to my occupational exposure to blood or other potentially infectious 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. I **decline** hepatitis B vaccination at this time. I understand that by declining the vaccine I continue to be at risk.

Signature of Artist: _____

Signature of healthcare provider: _____

Print name of healthcare provider: _____