HEPATITIS B VACCINATION DECLARATION

NAME		**RICE ID #**	
EMAIL		**PHONE #**	
DEPARTMENT		**PI**	

Please select one and complete on the sections below:

☐ **I WISH TO RECEIVE THE HEPATITIS B VACCINE**

The hepatitis B vaccination will be administered in 3 doses over a period of 6 months following a titer test to determine durability of immunity.	
Signature:	Date:

☐ **I DO NOT WISH TO RECEIVE THE HEPATITIS B VACCINE AT THIS TIME**

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 hepatitis B vaccine, I can receive the vaccination series at no charge to me.	
Signature:	Date:

☐ **I HAVE COMPLETED THE HEPATITIS B VACCINE SERIES**

Date of vaccination:	
Signature:	Date:

☐ **I HAVE PREVIOUS RECEIVED THE HEPATITIS B VACCINATION BUT REQUIRE A TITER TEST TO VERIFY IMMUNITY**

Signature:	Date:

Submit this completed *Hepatitis B Vaccination Declaration Form* to:

Rice University
Environmental Health and Safety
PO BOX 1892 MS123
Houston, TX 77005