**APPENDIX D**

**HEALTH CARE PROFESSIONAL’S WRITTEN OPINION FOR HEPATITIS B VACCINATION**

Employee Name:

Social Security Number:

Health Care Facility Address:

Health Care Facility Telephone:

As required under the bloodborne pathogen standard:

\_\_\_\_\_\_\_\_\_\_\_ Hepatitis B Vaccination IS indicated for this employee.

\_\_\_\_\_\_\_\_\_\_\_ Hepatitis B Vaccination IS NOT indicated for this employee; vaccination not received.

\_\_\_\_\_\_\_\_\_\_\_ The employee named is scheduled to receive the hepatitis B vaccination on the following dates:

 First of three:

 Second of three:

 Third of three:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Healthcare Provider’s Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

**Note: A copy of this form must be provided to the employee within 15 working days.**