

**Genesys Regional Medical Center  
Emergency Medical Services Education**

**Hepatitis B Vaccination/Declination Statement**

I, \_\_\_\_\_, understand that due to my participation in the Genesys EMS Education Program I may be exposed to blood or other potentially infectious materials and may be at risk of acquiring the Hepatitis B virus (HBV).

I understand that current OSHA/MIOSHA guidelines require employers to provide the Hepatitis B vaccine free of charge to employees in any occupation in which the employee MAY come in contact with blood or body fluids. I understand that my status as a student of the Genesys EMS Education Program does NOT qualify me as an employee of either Genesys Regional Medical center or the clinical agencies affiliated with Genesys. As such, I understand that I am required to have begun or completed the Hepatitis B vaccination series, either at my or my employer's expense, PRIOR to the start of clinical rotations.

I have read and understand the above information and indicate my HBV vaccination status below:

- I have begun or have completed the Hepatitis B vaccination series within the last ten years. (Proof of vaccination required) \_\_\_\_\_initial
  
- I have had a Hepatitis B titer drawn indicating immunity from the Hepatitis B virus. (Proof of appropriate titer required) \_\_\_\_\_initial
  
- I elect to receive the Hepatitis B vaccine at my own expense. I also request to have the vaccine administered by staff at Genesys Regional Medical Center. I have been advised of the risks and benefits and hereby give consent to Genesys Regional Medical Center to administer the vaccine to me.  
\_\_\_\_\_initial
  
- Dose #1 Lot# \_\_\_\_\_ Exp. \_\_\_\_\_ Site: \_\_\_\_\_  
Administered by: \_\_\_\_\_ Date: \_\_\_\_\_
  
- Dose #2 Lot# \_\_\_\_\_ Exp. \_\_\_\_\_ Site: \_\_\_\_\_  
Administered by: \_\_\_\_\_ Date: \_\_\_\_\_
  
- Dose #3 Lot# \_\_\_\_\_ Exp. \_\_\_\_\_ Site: \_\_\_\_\_  
Administered by: \_\_\_\_\_ Date: \_\_\_\_\_
  
- I decline the Hepatitis B vaccine at this time due to medical, religious or personal contraindications.  
\_\_\_\_\_initial

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date