CLINICAL STAFF SUPPORT, INC NURSING GROUP, INC

REQUEST TO RECEIVE HEPATITIS B VACCINE

I have completed blood borne pathogen training and have understood the information presented to me about hepatitis B virus and hepatitis B vaccine and have had the opportunity to ask questions My. Questions have been answered. I want to participate in hepatitis vaccination program I understand. This includes three (3) intramuscular injections over a six (6) month period. I understand that there is no guarantee that I will become immune to hepatitis B and that I might experience an adverse side effect as their result of the vaccination. Note: If you opt to receive the hepatitis B vaccine, you must report to the designated medical provider and or Clinical Staff Support, Inc and or Nursing Group, Inc via email within 10 working days of signing this form.

Employee Name: _____

Date of Birth: _____

Employee signature: _____ Date: _____

1st Dose: _____ _____ _____
Date Administered Administered by Title

_____
Lot#/Sticker

2nd Dose: _____ _____ _____
Date Administered Administered by Title

_____
Lot#/Sticker

3rd Dose: _____ _____ _____
Date Administered Administered by Title

_____
Lot#/Sticker

Please complete and return via Fax to: 800-331-1531 Or

Mail to: Nursing Group, Inc.
PO Box 446 Round Rock, Texas 78680-0446