"DECLINATION STATEMENT"

I, _____ as an employee of V.A.H.S.A.
(Employees Name)

with duties as a healthcare provider, I am aware of the signs, symptoms, causes, test, fatal affects, and treatments for Hepatitis B. I do hereby this date _____ decline the Hepatitis B vaccine, therefore putting myself at risk for Hepatitis B virus / infection.
(Date)

_____ (Office Manger Signature)

_____ (Employee's Signature)

P.O. Box 1334 / 401 Washington, St. Cambridge, MD 21613 (O) 443-225-5887 (F) 443-225-5892
Emails: visionsamerica@gmail.com

PHYSICIAN'S STATEMENT

Employee Information:

Name: _____ Date: _____

Address: _____

Social Security Number: _____

I have examined the above individual and found them to be in good physical and mental health. Furthermore, this individual appears to be free of communicable diseases and is able to function as a Health Care worker without restrictions.

Physician's Name: _____

Address: _____

Phone #: _____

Physician's Signature and Date: _____

Notes:

_____

_____

_____

_____

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Emails: visionsamerica@gmail.com / sharonwilson11@msn.com

TUBERCULIN TEST

Employee Information:

Name: _____ Date: _____

Address: _____

Social Security Number: _____

**** FOR PPD, PLEASE INDICATE "MM's OF INDURATION. ****
A "NEGATIVE" RESULT IS NOT ACCEPTABLE.

	Date	Result	Expiration Date
Chest X-Ray or PPD / Monteux	_____	_____	_____

Physician's Name: _____

Address: _____

Phone #: _____

Physician's Signature and Date: _____

Notes:

_____

_____

_____

_____