

BOARD OF
COUNTY COMMISSIONERS
COUNTY OF GLOUCESTER

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DEPARTMENT OF HEALTH
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The County of Gloucester complies with all state and federal rules and regulations against discrimination in admission to, access to, or operations of its programs, services, and activities. In addition, the County encourages participation of people with disabilities in its programs and activities and offers special services to all residents 60 years of age and older. Inquiries regarding compliance may be directed to the County's ADA Coordinator at (856) 384-6842/ New Jersey Relay Service 711.



HEPATITIS B VACCINE ACCEPTANCE / DECLINATION FORM

ACCEPTANCE:

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of being infected by bloodborne pathogens, including Human Immunodeficiency Virus (HIV) and Hepatitis B (HBV). This is to certify that I have been informed about the symptoms and the hazards associated with these viruses, as well as the modes of transmission of bloodborne pathogens. I have been given the opportunity to be vaccinated with Hepatitis B vaccine, at no charge to myself. In addition, I have received information regarding the Hepatitis B vaccine (HBV). Based on the training I have received; I am making an informed decision to accept the Hepatitis B vaccine (HBV).

DECLINATION:

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.

CHECK ONE:

I ACCEPT Hepatitis B vaccine inoculation: OR

I DECLINE Hepatitis B vaccine inoculation.

Employees Name: _____

Employees Signature: _____ Date: _____