

**THE UNIVERSITY OF NORTH CAROLINA at GREENSBORO
HEALTHCARE PROFESSIONAL'S OPINION
FOR HEPATITIS B VACCINATION**

Employee's Name:

Social Security Number:

NOTE: This form is to be completed prior to the administration of an employee's first Hepatitis B Vaccination.

To The Evaluating Healthcare Professional:

After you have determined whether there are contra indications to vaccination of this UNCG employee with Hepatitis B vaccine, please state in the space below **only**

(A) if vaccine was indicated ___Yes ___No

(B) if vaccine was received ___Yes ___No

(All other findings are to remain confidential and are not to be included on this page.)

Please return this sheet to this employee _____(name of employee).
Thank you for your evaluation of this employee.

Healthcare Professional's Signature: _____Date:

Healthcare Professional's Name (printed): _____

Copies to: Office of Safety, Employee