

## HEALTH CARE PROVIDER'S WRITTEN OPINION FOR HEPATITIS B VACCINATION

<b>Employee's Name:</b>
<b>Date of Evaluation:</b>
<b>Health Provider's Address:</b>
<b>Health Provider's Telephone Number:</b>

As required by the Occupational Exposure to Bloodborne Pathogens rule, Chapter 296-823 WAC:

Hepatitis B vaccination is \_\_\_\_ is not \_\_\_\_ recommended for the employee named above.

The employee named above is scheduled to receive 3 total hepatitis B vaccinations on the following dates:

1<sup>st</sup> of 3: \_\_\_\_\_

2<sup>nd</sup> of 3: \_\_\_\_\_

3<sup>rd</sup> of 3: \_\_\_\_\_

\_\_\_\_\_  
Health Care Provider's Name

\_\_\_\_\_  
Health Care Provider's Signature

\_\_\_\_\_  
Date

**Return this form to the employer and provide a copy to the employee within 15 days of receipt. Please label the outside of the envelope "Confidential." Thank you.**

Facility Name: \_\_\_\_\_

Facility Address: \_\_\_\_\_

Confidential Fax: \_\_\_\_\_