IMMUNIZATION STATUS FORM

OSHA, the Occupation Safety and Health Administration, strongly recommends all individuals who have occupational exposure to potentially infectious materials receive the **Hepatitis-B Vaccine**.

Please have your doctor complete the information below or attach record, sign, date and return to Dental Works.

Patient Name: _____ **DOB:** _____

Hepatitis B

1. I have received the complete Hepatitis B Vaccination Series (3shots)	**Date of Immunizations** **1.**_____ **2.**_____ **3.**_____
2. Serologic Proof of Immunity: **Titer Date:**_____	☐ **Positive for antibodies** ☐ **Negative for antibodies** ☐ **I never tested for antibodies** ☐ **Refusal to receive immunizations**

The following are **not required, however, highly recommended, for employment placement opportunities from Dental Works, LLC**. Please confirm the following and provide proof if applicable:

Vaccine	Date of Vaccination	Date of Titer	Serologic Proof of Immunity
☐ **Measles, Mumps, Rubella (MMR)**	**1.**_____ **2.**_____		☐ **Positive** ☐ **Negative**
☐ **Varicella (Var)**	**1.**_____ **2.**_____		☐ **Positive** ☐ **Negative**
☐ **Diphtheria, Tetanus, Pertussis**	**1.**_____ **2.**_____ **3.**_____ **4.**_____		☐ **Positive** ☐ **Negative**
☐ **TB Implant (PPD) Yearly**	**1.**_____ **2.**_____	**Date of Chest X-ray** _____	☐ **Positive** ☐ **Negative**
☐ **Flu (Yearly)**	**1.**_____		

Doctor Name: _____

Doctor Signature: _____ **Date:** _____