**HEPATITIS B VACCINE**

**DECLINATION/CONTRAINDICATION FORM**

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 or any other blood-borne illness. I have been given the opportunity to be vaccinated with Hepatitis B vaccine. I have elected to do one of the following:

\_\_\_\_\_\_ (Initial) Be vaccinated with Hepatitis B vaccine, and I have a copy of my Hepatitis B vaccination which shall remain on file in my place of business and shall be available for inspection upon request; or

\_\_\_\_\_\_ (Initial) Declined to be vaccinated with Hepatitis B vaccine, and I have been given a copy of this Declination of Hepatitis B vaccine form which shall remain on file in my place of business and shall be available for inspection upon request; or

\_\_\_\_\_\_ (Initial) Declined to be vaccinated with Hepatitis B vaccine because my Hepatitis B antibody testing revealed that I am immune to Hepatitis B, and I have a copy of my Hepatitis B antibody testing results which shall remain on file in my place of business and shall be available for inspection upon request; or

\_\_\_\_\_\_\_ (Initial) Declined to be vaccinated with Hepatitis B vaccine because I have provided a dated and signed physician’s statement specifying that I may not be given the Hepatitis B vaccine for medical reasons, and I have a copy of this Contraindication to Hepatitis B form and my physician’s statement which shall remain on file in my place of business and shall be available for inspection upon request.

If I declined the Hepatitis B vaccine at this time, I knowingly and willing assume the risk of any harm and/or liability that I may incur as a result of my failure to be vaccinated with Hepatitis B vaccine. I also understand that any and all clients have a legal right to ask to review my vaccination, declination of vaccination, or contraindication for vaccination information upon request.

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Tattoo Artist Signature Print Name Date

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Body Art Studio Address Phone

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Health Department Witness Signature Witness’ Position Date