

## PHYSICIANS STATEMENT

Please attest to the fact that:

Name: \_\_\_\_\_ Job Title \_\_\_\_\_  
 Address \_\_\_\_\_ Phone \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Social Security Number \_\_\_\_\_ Date \_\_\_\_\_

Has been examined by you and is able to physically perform the basic job functions and is free of communicable diseases.

|                                    |                |            |
|------------------------------------|----------------|------------|
| <b>Chest X-Ray or TB Skin Test</b> | Results: _____ | Date _____ |
| <b>Color Vision Test</b>           | Results: _____ | Date _____ |
| <b>Mumps</b>                       | Results: _____ | Date _____ |
| <b>Rubeola (Measles) Titer</b>     | Results: _____ | Date _____ |
| <b>Rubella Titer</b>               | Results: _____ | Date _____ |
| <b>Varicella (Chicken Pox)</b>     | Results: _____ | Date _____ |
| <b>Tetanus</b>                     | Date: _____    |            |

### Hepatitis B

Please indicate one of the following:

- \_\_\_\_\_ The Hepatitis B vaccination has been received (attached is a copy of documentation)
- \_\_\_\_\_ Antibody testing showing immunity. - (Attached is a copy of physician's statement)
- \_\_\_\_\_ Vaccine Received, however there has been no immune liter response.
- \_\_\_\_\_ The vaccine cannot be given for medical reasons - (see physician's statement)
- \_\_\_\_\_ I refuse the hepatitis vaccine for personal reasons

I understand that I may be at risk of acquiring Hepatitis-B as a result of my occupational exposure to blood and other potentially infectious materials. I have been given the opportunity to be vaccinated with the Hepatitis-B vaccine, and I choose to decline at this time. I acknowledge that I continue to be at risk of acquiring Hepatitis-B, a serious disease. I understand that I can receive the vaccination series at a future time if I continue to have exposure to blood or other potentially infectious materials.

\_\_\_\_\_  
 Employee Signature Date

**Physician's Signature:** \_\_\_\_\_  
**Print Name:** \_\_\_\_\_ **Date** \_\_\_\_\_  
**Address:** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

Please attach copies of lab tests if you already have them.

*Mail or Fax completed statement to:*