**UNIVERSITY OF FLORIDA**

**BLOODBORNE PATHOGEN PROGRAM**

for individuals having contact with

**HUMAN BLOOD OR OTHER POTENTIALLY INFECTIOUS MATERIALS**

**Training and Vaccination Form**

**Acceptance/Declination Statement**

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1. **I have received training on the risks of working with human blood or other potentially infectious materials as outlined in the University of Florida’s Bloodborne Pathogen Program.**

   - **DN-Clinic Administration**
     - UF Department Providing Training
     - Date of Training
   - **S. Scrambling**
     - Trainer

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<th>Date of Training</th>
<th>Trainer</th>
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2. **In full recognition of the above**

   - □ I accept participation in the vaccination series and have not yet been vaccinated.
   - □ Take a copy of this form to the Student Health Care Center (see info below) to begin the vaccination series.
   - □ Jacksonville personnel go to the Employee’s Health Office, Suite 505 Tower 1, 5th floor, 8th and Jefferson Streets.
   - □ I received the HBV vaccination series on __________, __________, & __________.
   - □ (dates - month/year is essential)
   - □ I decline participation in the vaccination series.

   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. I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to myself. However, I decline the hepatitis B vaccine at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If, in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

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**Signature**

**Name (Please print)**

**Date**

**Volunteer**

- **UF ID #**
- **Position Title (Official UF)**
- **Position #**
- **PO Box 100412**
- **Campus Mailing Address**
- **Phone**

**S. Scrambling**

- **Supervisor/PI Signature**
- **Supervisor/PI Name (Please print)**
- **Date**

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**Please Note:** This form, completed in full, is required to get a HBV vaccination at the Student Health Care Center and to decline vaccination if desired. Photocopy this form as needed.

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**Main Office for Occupational Health:**

**Student Health Care Center at the Health Center Dental tower**

- D2-49 (352) 294-5700
- Call for appointment

**Satellite office:**

**Student Health Care Center - Infirmary**

- 392-1161 x4212
- Call for appointment

If declining vaccination or providing dates, return the form to your departmental BBP training coordinator who will attach it to the list of those trained in your department and send to Box 112190.

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EHS-BBP-T&V rev 10/2012