



## HEPATITIS B IMMUNIZATION STATUS

Name: \_\_\_\_\_  
Surname First Name

Principal Investigator's Name: \_\_\_\_\_

Department Name and Address: \_\_\_\_\_

Department Phone Number: \_\_\_\_\_

I received Hepatitis B vaccine on the following dates at:

\_\_\_\_\_ Location (Clinic, doctor's office, Health Authority and town/city/country)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Post vaccination antibody test  Yes  No

If yes, the result was \_\_\_\_\_

Please attach all documentation if available.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please return to JoAnne Seglie, Occupational Health Nurse, at the above address.

This information is being collected under the authority of the Freedom of Information and Protection of Privacy Act (Section 33c.) By completing and submitting this information, you are consenting to the collection and use of this information for the purpose of *early illness intervention through medical surveillance*. Should you have any questions about this collection of personal information, contact the Office of Environmental Health & Safety, Rm 107, 11390-87 Ave., University of Alberta, telephone 780-492-5378, fax 780-492-7790.