



**Department of Veterans Affairs  
Medical Center  
1670 Clairmont Road  
Decatur, GA 30033**

**Hepatitis B Vaccine  
Waiver Statement**

Name: \_\_\_\_\_

School: \_\_\_\_\_

Faculty Name: \_\_\_\_\_

Location of Clinical: \_\_\_\_\_ Date of Clinical: \_\_\_\_\_

I am aware of the personal health hazard of contracting Hepatitis B. If contracted Hepatitis B may cause serious health problems, including death.

I have been advised to take the Hepatitis B vaccine, which consists of a series of 3 injections, administered over a 6-month period. At the present time I:

\_\_\_\_\_ have declined to have the Hepatitis B vaccine.

\_\_\_\_\_ have started, but have not completed the series.

\_\_\_\_\_ I have completed the Hepatitis B vaccine series, but I do not have documentation.

I agree to assume the responsibility for any consequence I might suffer should I decide either not to start or not to complete the Hepatitis B vaccine series.

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

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