UNIVERSITY OF FLORIDA BLOODBORNE PATHOGEN PROGRAM

Training and Vaccination Form Acceptance/Declination Statement

Complete the information below, *including signature*, and send us the finished form.

Official submission of this form for processing is directly to *EH&S, Biosafety Office*

MAIL: EH&S, Biosafety Office, Box 112190, Gainesville, FL 32611,

EMAIL: BSO@ehs.ufl.edu or **FAX:** 352 392-3647

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Full Name *(please print)*	UFID#	Department	UF Position Title	Contact Phone #

A. Annual training regarding the risks of working with human blood or other potentially infectious materials (OPIM) as outlined in the University of Florida's Bloodborne Pathogen Program is required.
I acknowledge that this training is required annually but completion of this form is only required ONCE.

I have completed the online training program in myTraining within the last 12 months.

My training was provided by my department trainer: ______________________ on ______________
Trainer Name *Date Trained*

I have not completed the training.

B. In full recognition of the content provided in the required ANNUAL training, choose ONE of the following. *Please ensure that the vaccination series is not required for your position if declining.*

1. I **ACCEPT** participation in the vaccination series and **HAVE NOT** received the full 3-shot vaccination series yet. My department's fiscal contact information is as follows:

Name: ______________________ Email: ______________________ Phone: ________________

Call for appointment:

UF Gainesville
Student Health Care Center (SHCC)
Health Center Dental tower, Room D2-49
(352) 294-5700

UF Jacksonville
Employee Health Office, Suite 505
Tower 1, 5th floor, 8th and Jefferson Streets
(904) 244-9576

2. I **DECLINE** participation in the vaccination series because I have **COMPLETED** the full 3-shot series. I acknowledge that should an exposure take place, I have not falsified this information and I am protected by the vaccination series.

3. I **DECLINE** participation in the full vaccination series. By declining the hepatitis B vaccine at this time, I acknowledge and understand that:

a. due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring hepatitis B virus (HBV) infection;
b. I continue to be at risk of acquiring hepatitis B, a serious disease;
c. I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to myself;
d. 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.

C. By signing this document I acknowledge:

receipt of the above information;

responsibility for continuing to complete the required annual training as needed;

that the information provided here is correct;

that by accepting participation in the Bloodborne Pathogen Program, I will provide a copy of my vaccination records, from my medical provider to the OCCMED Clinic.

Submit

______________________________ ______________
Signature Date