

\*\*\*\*\* NOTICE TO SUPERVISOR \*\*\*\*\*  
**MEDICAL CENTER POLICY MANDATES THIS FORM BE COMPLETED AND RETURNED TO  
 STUDENT/EMPLOYEE HEALTH WITHIN TEN (10) DAYS OF EMPLOYMENT.**

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**RISK OF EXPOSURE TO HEPATITIS B VIRUS  
 OR HUMAN IMMUNODEFICIENCY VIRUS  
 University of Mississippi Medical Center**

DATE \_\_\_\_\_

UNIT/DEPT. \_\_\_\_\_

NAME \_\_\_\_\_

JOB TITLE \_\_\_\_\_

ID NUMBER \_\_\_\_\_

\_\_\_\_\_  
 SUPERVISOR'S SIGNATURE

A. This position involves the following work-related tasks:

	YES Routine Task	NO-But May Be Required	NO- Never Done		YES Routine Task	NO-But May Be Required	NO- Never Done
Bathes patients, including patients incontinent of urine and feces	( )	( )	( )	Intubates patients or administers mouth-to-mouth resuscitation	( )	( )	( )
Examines patients including oral, rectal, vaginal, or wound examination	( )	( )	( )	Cleans instruments and other medical devices contaminated by blood or body fluids	( )	( )	( )
Draws blood or gives medications using needle and syringe	( )	( )	( )	Performs medical laboratory tests such as cultures, blood typing, and biopsies	( )	( )	( )
Performs or assists during invasive treatment of patients such as bronchoscopy, gastroscopy, insertion of central venous or arterial lines	( )	( )	( )	Picks up or processes biological waste or trash that may contain items contaminated by blood or body fluids	( )	( )	( )
Performs surgery or scrubs during surgical procedures	( )	( )	( )	Administers EEG or EMG tests using needle electrodes	( )	( )	( )
Applies dressings to post-op wounds or fresh lacerations	( )	( )	( )	Performs research using human blood, body fluids, or tissues	( )	( )	( )
Inserts, changes or empties drainage tubes	( )	( )	( )	Performs or assists with autopsies	( )	( )	( )

Other job-related tasks that may involve exposure to blood, body fluids, or tissues (Specify)

\_\_\_\_\_  
 \_\_\_\_\_

B. The risk of exposure to Hepatitis B Virus or Human Immunodeficiency Virus in the performance of this job is classified as: (Check one only)

- ( ) **CATEGORY I** - The employee performs tasks that involve an inherent potential for mucous membrane or skin contact with blood, body fluids, tissues or a potential for spills or splashes. Universal precautions should be applied for all procedures or patient care when it is likely that the employee will have contact with blood or body fluids to prevent transmission of blood-borne pathogens.
- ( ) **CATEGORY II** - The employee performs tasks that involve no exposure to blood, body fluids, or tissues during the normal work routine, but the employee may be required to perform unplanned Category I tasks. Universal precautions should be used to perform any Category I procedures.
- ( ) **CATEGORY III** - The employee performs tasks that involve no exposure to blood, body fluids, or tissues during the normal work routine. No special precautions are necessary to prevent transmission of blood-borne pathogens.

## Information about Hepatitis B vaccine (Recombinant)

### The Disease

Hepatitis B is a viral infection caused by the hepatitis B virus (HBV) which causes death in 1-2% of patients. Most people with hepatitis B recover completely, but approximately 5-10% become chronic carriers of the virus. Most of these people have no symptoms, but can continue to transmit the disease to others. Some may develop chronic active hepatitis and cirrhosis. HBV also appears to be a causative factor in the development of liver cancer. Thus, immunization against hepatitis B can prevent acute hepatitis and also reduce sickness and death from chronic active hepatitis, cirrhosis and liver cancer.

### The Vaccine

Hepatitis B vaccine is made using recombinant DNA technology with no serum from human donors. A high percentage of healthy people who receive three doses of vaccine achieve high levels of surface antibody (anti-HBs) and protection against hepatitis B. Full immunization requires 3 doses of vaccine over a six month period. There is no evidence that the vaccine has ever caused hepatitis B or AIDS. However, persons who have been infected with HBV prior to receiving the vaccine may go on to develop clinical hepatitis in spite of immunization. The duration of immunity is unknown at this time but is probably long term.

### Possible Vaccine Side Effects

The incidence of side effects is very low. No serious side effects have been reported with the vaccine. A few persons experience tenderness and redness at the site of injection. Low grade fever may occur. Rash, nausea, joint pain and mild fatigue have also been reported. The possibility exists that more serious side effects may be identified in the future.

If you have any questions about hepatitis B or hepatitis B vaccine, please ask.

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### CONSENT FORM

I have read the above statement about hepatitis B and the hepatitis B vaccine. I have had an opportunity to ask questions and understand the benefits and risks of hepatitis B vaccination. I understand that I must have 3 doses of vaccine to confer immunity. However, there is no guarantee that I will become immune or that I will not experience an adverse side effect from the vaccine. I request that it be given to me or the person named below of whom I am the parent or guardian.

	Date Vaccinated	Lot #
_____	(1) _____	_____
_____	(2) _____	_____
_____	(3) _____	_____

Print Name of Person to Receive Vaccine                      Date Signed

\_\_\_\_\_  
Signature of Person Receiving Vaccine or Parent/Guardian

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_____	_____	_____	_____
Address	City	State	Zip Code
_____	_____	_____	_____
Social Security Number	Date of Birth	Employee # or Student Status	

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### DECLINATION FORM

( ) No, I do not want to receive hepatitis B vaccine. I have been given the opportunity to be vaccinated with hepatitis B vaccine at no charge to myself. However, I decline hepatitis B vaccination 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 want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

( ) No, I have completed the Hepatitis B vaccine series.

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_____	_____	_____
Signature of Employee	Date Signed	Printed Name of Employee

File: Employee Health Record

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