**HEPATITIS B BOOSTER AND HEPATITIS B SECOND SERIES FORM**

**Hepatitis B Booster AND 2nd Titer Required**

<table>
<thead>
<tr>
<th>Booster Date:</th>
<th>Initials:</th>
<th>Titer #2 (1-2 months after booster)</th>
<th>Date:</th>
<th>Initials:</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Dose #4)</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Circle result: Positive  Negative  Indeterminate

**IMPORTANT:** If your booster titer result above is negative or indeterminate, you are required to repeat the full series of Hepatitis B doses and titer. Heplisav-B vaccine series is accepted. See below:

**Hepatitis B (Complete this only if titer above is negative or indeterminate)**

<table>
<thead>
<tr>
<th>Date</th>
<th>Initials</th>
<th>Date</th>
<th>Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dose #5 date:</td>
<td></td>
<td>Dose #5 date:</td>
<td></td>
</tr>
<tr>
<td>Dose #6 date:</td>
<td></td>
<td>Dose #6 date:</td>
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</tbody>
</table>

Timeline for doses: Receive 1st dose, receive 2nd dose 1 month later, receive 3rd dose 4 months from 1st dose; Receive titer 1 to 2 months after 3rd dose.

Healthcare provider: If Heplisav-B is used, please note on Dose 4 and 5.

**3RD TITER**

Date and result of lab titer:

Hep B Surface Ab date: _________

Circle result: positive  negative  indeterminate

Health Care Provider Initials: _________

**Licensed Health Care Provider Attestation**

By signing below, I affirm that I am a licensed health care provider. I am aware that leaving any required fields blank will result in the student being unable to progress in his/her major at the University of Vermont.

Signature of Licensed Health Care Provider:  
Credentials:  
Date:  
Clinic Stamp or Printed Name of Provider:  
Provider Telephone Number:  

The information included on this form may be released to the infection control officer and clinical education coordinators at sites where you perform your clinical education experience.