



## HEPATITIS B IMMUNIZATION

LAST NAME: Ladson

FIRST NAME: Jasmine

TSSC ID #: AD1284297

HAVE YOU COMPLETED A SERIES OF HEPATITIS B IMMUNIZATION? IF "YES" - SEE STEP 1 & IF "NO" SEE STEP 2.

**HEPATITIS B TITER - TO BE COMPLETED BY YOUR HEALTHCARE PROVIDER.**

**STEP 1 - IF YOU HAVE COMPLETED A HEPATITIS B SERIES IN THE PAST - HAVE A TITER DRAWN AND COMPLETE THE FOLLOWING.**  
PLEASE NOTE THAT IF YOUR TITER IS NEGATIVE YOU MUST COMPLETE STEP 2.

DATE OF TITER: \_\_\_\_\_ POSITIVE? \_\_\_\_\_ (anti-HBs  $\geq$  10 mIU/mL) NEGATIVE? \_\_\_\_\_ (anti-HBs  $\leq$  10 mIU/mL) (please identify results with a  $\checkmark$ )

PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS (PLEASE PRINT) \_\_\_\_\_

PHYSICIAN/NURSE PRACTITIONER SIGNATURE \_\_\_\_\_

Provider:  
Please place office stamp  
here (if possible) for  
validation purposes.

**IF YOUR TITER RESULTS ARE POSITIVE - YOU ARE DONE!  
IF YOUR RESULTS ARE NEGATIVE - COMPLETE STEP 2 BELOW.**

**STEP 2 - IF YOU HAVE NOT COMPLETED A HEPATITIS B IMMUNIZATION OR IF YOU HAD A NEGATIVE TITER - A FULL 3-PART SERIES IMMUNIZATION IS REQUIRED.**

1ST VACCINATION DATE: 12/29/06

PHYSICIAN/NURSE PRACTITIONER SIGNATURE: \_\_\_\_\_

STUDENT HEALTH CENTER  
IRMA B. MOORE HALL RM. 102  
P.O. BOX 244023  
MONTGOMERY, AL 36124-4023

2ND VACCINATION DATE: 1/29/07  
TO BE ADMINISTERED 1 MONTH AFTER 1ST DOSE

PHYSICIAN/NURSE PRACTITIONER SIGNATURE: \_\_\_\_\_

Provider:  
AUBURN UNIVERSITY MONTGOMERY  
STUDENT HEALTH CENTER  
IRMA B. MOORE HALL RM. 102  
P.O. BOX 244023  
MONTGOMERY, AL 36124-4023

3RD VACCINATION DATE: 11/30/20  
TO BE ADMINISTERED 6 MONTHS AFTER 2ND DOSE

PHYSICIAN/NURSE PRACTITIONER SIGNATURE: \_\_\_\_\_

Provider:  
AUBURN UNIVERSITY MONTGOMERY  
STUDENT HEALTH CENTER  
IRMA B. MOORE HALL RM. 102  
P.O. BOX 244023  
MONTGOMERY, AL 36124-4023

**AFTER COMPLETION OF THE FULL 3-PART SERIES, HAVE A TITER DRAWN FOR HEPATITIS B ANTIBODY TO DOCUMENT IMMUNITY:**

DATE OF TITER: \_\_\_\_\_ POSITIVE? \_\_\_\_\_ (anti-HBs  $\geq$  10 mIU/mL) NEGATIVE? \_\_\_\_\_ (anti-HBs  $\leq$  10 mIU/mL) (please identify results with a  $\checkmark$ )

PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS (PLEASE PRINT) \_\_\_\_\_

PHYSICIAN/NURSE PRACTITIONER SIGNATURE \_\_\_\_\_