



HEPATITIS B IMMUNIZATION

LAST NAME: Giovacchino

FIRST NAME: Michael

TSSC ID #: A00656990

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: 6/10/24 POSITIVE? ☐ (anti-HBs ≥ 10 mIU/mL) NEGATIVE? ☒ (anti-HBs ≤ 10 mIU/mL) (please identify results with a $\checkmark$)

PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS (PLEASE PRINT) Steven L Allen MD

PHYSICIAN/NURSE PRACTITIONER SIGNATURE [Signature]

Steven L. Allen, MD

2175 Hwy 31 N

Deatsville, AL 36022

(334) 358-3777
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: 6/13/2024

AUBURN UNIVERSITY MONTGOMERY

STUDENT HEALTH CENTER

IRMA B. MOORE HALL RM. 102

Provider:

P.O. BOX 244023

Please place office stamp

MONTGOMERY, AL 36124-4023

here (if possible) for validation purposes.

2ND VACCINATION DATE: 7/15/2024
TO BE ADMINISTERED 1 MONTH AFTER 1ST DOSE

AUBURN UNIVERSITY MONTGOMERY

STUDENT HEALTH CENTER

IRMA B. MOORE HALL RM. 102

Provider:

P.O. BOX 244023

Please place office stamp

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here (if possible) for validation purposes.

3RD VACCINATION DATE: 01/15/2025
TO BE ADMINISTERED 6 MONTHS AFTER 2ND DOSE

AUBURN UNIVERSITY MONTGOMERY

STUDENT HEALTH CENTER

IRMA B. MOORE HALL RM. 102

Provider:

P.O. BOX 244023

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

DATE OF TITER: 2/14/2025 POSITIVE? ☒ (anti-HBs ≥ 10 mIU/mL) NEGATIVE? ☐ (anti-HBs ≤ 10 mIU/mL) (please identify results with a $\checkmark$)

PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS (PLEASE PRINT) Lindsey Barton, CRNP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE [Signature]

[Signature] CRNP
Lindsey Barton, CRNP

[Signature] CRNP
J. Barton, CRNP

[Signature] CRNP
J. Barton, CRNP

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