Rocky Mountain University of Health Professions

PHYSICIAN ASSISTANT PROGRAM - HEPATITIS B FORM

Last Name:______________________ First Name: ______________________ Middle Name: __________________

Date of Birth (*mm/dd/yyyy*): ___________________

Preferred Telephone Number: ______________________________ E-mail: __________________________________

Instructions from CDC:

- Unvaccinated healthcare personnel (HCP) and/ or those who cannot document previous vaccination should receive either a 2-dose series of Heplisav-B at 0 and 1 month or a 3-dose series of either Engerix-B or Recombivax HB at 0, 1, and 6 months.
- If HB Titer is less than 10 mIU/mL (negative), the person is not protected from hepatitis B virus (HBV) infection and should receive another 2-dose or 3-dose series of HepB vaccine on the routine schedule, followed by anti-HBs testing 1–2 months later. A person whose anti-HBs remain less than 10 mIU/ mL after 2 complete series is considered a “non-responder.”

Documentation of Proof of Immunity

Risk	Standard	Evidence				
		Second Titer Results* (to be taken **1-2 months** after an additional vaccination series or booster)	Dates and Series of Vaccines Administered			If applicable, date confirmed Non-Responder (seronegative after 2 series)
Hepatitis B	Second titer validating current immunity (≥ 10mIU/ml)	Immune: Y N				
		Date of Titer: ____________				

*****The RMUoHP PA program does not require submission of actual titer lab results. However, applicants must have immunization status reviewed by a medical provider, and this form must be filled out and signed by the reviewing MD, DO, PA, or NP.

Provider signature: ____ Date: __________________
Licensed Medical Provider (MD, DO, PA, NP)

Name and credential of signing provider (please print): ____

Address of signing provider (please print): ____