Employee Training Record

Office Name: ______________________________

Office Address: ______________________________

____

Date of training session: ______________________________

Name(s) and qualifications of person conducting training session:

____

____

Contents/Summary of training session:

____

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Names and job titles of all persons attending training session:

Name	Job Title

Make copies of this page as needed.
Note: Training records document each training session and must be retained by the employer for three years. They should be made available upon request to employees or OSHA representatives.

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Employee Medical Record

Employee name: ______________________________

Employee address: ______________________________

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Employee social security number: ______________________________

Employee starting date: ______________________________

Employee termination date (if any): ______________________________

History of HBV vaccination (date received, or, if not received, a brief explanation of why not):

____

____

____

History of exposure incident(s) (dates, brief explanation, attachments):

____

____

____

Results of medical exams and follow-up procedures regarding exposure incident or hepatitis B immunity, including written opinion of healthcare professional (dates, brief explanation, attachments):

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____

____

Information provided to the healthcare professional regarding hepatitis B vaccination and/or exposure incident(s) (dates, brief explanation, attachments):

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Note: Maintain this record for duration of employment plus 30 years. Medical records of employees who have worked for less than one year need not be retained beyond the term of employment if the records are provided to the employee upon termination of their employment.

Confidential

Note to employer: This form should be signed by the healthcare professional twice: after the first vaccination and again when the series is completed. If vaccination is not indicated, only one signature is necessary. Maintain this record for the duration of employment plus 30 years. Provide a copy to the employee within 15 days of the initial evaluation.

Hepatitis B Vaccination
Healthcare Professional's Written Opinion

For

____

[NAME OF EMPLOYEE]

To the healthcare professional:
OSHA requires the healthcare professional who evaluates an employee for hepatitis B vaccination to provide a written opinion in the form provided below. Please complete this form and return it to the employee at the time services are rendered. Thank you for your cooperation.

I hereby certify that on [**DATE**] ____

I evaluated the employee [**NAME**] ____

and determined that hepatitis B vaccination:

☐ Is indicated for this employee

☐ Is not indicated for this employee.

In addition, the employee:

☐ Did ☐ Did not receive

the first hepatitis B vaccination.

Signed: ________________________________ Date: ____________________

[HEALTHCARE PROFESSIONAL]

The employee:

☐ Did ☐ Did not receive

the entire series of 3 hepatitis B vaccinations.

Signed: ________________________________ Date: ____________________

[HEALTHCARE PROFESSIONAL]

Hepatitis B Vaccine Declination

Confidential

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with the 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 continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with the hepatitis B vaccine, I can receive the vaccination series at no charge to me.

Signature:______________________________ Witness:______________________________

Date:______________________________ Date:______________________________

Name:______________________________

Address:______________________________

City:__________________ State:_____ Zip:__________

Note: Maintain this record for duration of employment plus 30 years. Medical records of employees who have worked for less than one year need not be retained beyond the term of employment if the records are provided to the employee upon the termination of their employment.

Confidential

Note to employer: Maintain this record for duration of employment plus 30 years. Provide a copy to the employee within 15 days after the evaluation is completed.

Post-exposure Evaluation and Follow-up Healthcare Professional's Written Opinion

For

____
[NAME OF EMPLOYEE]

To the healthcare professional:

OSHA requires the healthcare professional who provides post-exposure evaluation and follow-up services to an employee to provide a written opinion in the form provided below. Please complete this form and return it to the employee at the time services are rendered. Thank you for your cooperation.

I hereby certify that on [**DATE**] ______________________________ I evaluated the employee,

[**NAME**] ____,

and informed the employee of the results of the evaluation; and any medical conditions resulting from exposure to blood or other potentially infectious materials which require further evaluation or treatment.

NOTE: ALL OTHER FINDINGS OR DIAGNOSES ARE CONFIDENTIAL AND SHOULD NOT BE INCLUDED IN THIS WRITTEN REPORT.

Signed: ______________________________ Date: ______________________
[HEALTHCARE PROFESSIONAL]

Informed Refusal by Employee of Post-exposure Medical Evaluation

Confidential

I, [**NAME**] ________________________________, am employed by

[**PRACTICE NAME**]________________________________, as a [**POSITION**]________________________.

My employer has provided training to me regarding exposure control for bloodborne pathogens and the risk of disease transmission in the dental office.

On [**DATE**]________________________________, I was involved in an exposure incident when [**DESCRIBE DETAILS OF EXPOSURE INCIDENT HERE**]

____

____

____

My employer has offered to provide post-exposure medical evaluation and follow-up for me in order to assure that I have full knowledge of whether I have been exposed to or contracted an infectious disease from this incident.

However, I, of my own free will and volition, and despite my employer's offer, have elected not to have a medical evaluation.

Signature:________________________________ Witness:________________________________

Date:________________________________ Date: ________________________________

Name: ________________________________

Address: ________________________________

City: ________________ State: _____ Zip:__________

Note: Maintain this record for duration of employment plus 30 years. Medical records of employees who have worked for less than one year need not be retained beyond the term of employment if the records are provided to the employee upon the termination of their employment.