uOttawa

Student Placement Risk Management

Hepatitis B Second Immunization Series and Serology Follow-up

Program

Medicine ❒ ❑ Undergraduate ❑ Postgraduate ❑ Postgraduate Elective	**Nursing** ❒ ❑ Generic program (select campus): □ Ottawa □ Woodroffe □ Pembroke ❑ Bridging ❑ 2nd Entry ❑ Graduate MScN ❑ Diploma in PHCNP	**Rehabilitation** ❒ ❒ Audiology ❑ Occupational Therapy ❑ Physiotherapy ❑ Speech-Language Pathology	**Education** ❒ ❑ Undergraduate ❑ Master of Education in Counselling Psychology	**Social Sciences** ❒ ❑ Clinical Psychology ❑ Social Work
		Nutrition ❒	**Sciences** ❒ ❑ Ophthalmic Medical Technology	**Human Kinetics** ❒

Last name:_____ **First name:**_____

Student number:_____ **Year of admission:**_____

Email:_____ **Telephone:**_____

Date of birth (yy/mm/dd):_____/_____/_____ □ **Male** □ **Female** □ **Non-Binary**

Primary Documentation

Initial vaccination series: ❑ None on file

Dose 1: (yy-mm-dd)____/____/____ Dose 2: (yy-mm-dd)____/____/____ If applicable, Dose 3: (yy-mm-dd)____/____/____

Serology (blood work):

Negative hepatitis B surface antibody result: Date (yy-mm-dd)____/____/____

Negative hepatitis B surface antigen result: Date (yy-mm-dd)____/____/____

FOLLOW-UP

To be completed by the Health Care Provider

If identified as non-immune (<than 10IU/L) and HBs Ag is negative

Please provide the following:

Obtain and provide date of **first booster vaccine** (yy-mm-dd)____/____/____

Provide date and result of Hep B surface antibody blood test **(attach lab report).**
BLOOD TEST MUST BE DONE 30 DAYS AFTER FIRST BOOSTER VACCINE, NO EARLIER

Anti-HBs: Date (yy-mm-dd)____/____/____ Result:_____IU/ml If ≥than 10IU/L **no further action**
If <than 10IU/L **proceed to second (2nd) and third (3rd) booster vaccines**

Obtain and provide date of **second booster vaccine** (yy-mm-dd)____/____/____
Must be done **1 month (minimum of 28 DAYS)** from the first booster

Obtain and provide date of **third booster vaccine** (yy-mm-dd)____/____/____
Must be done **5 months** after the second booster vaccine

Provide date and result of Hep B surface antibody **blood test (attach lab report).**
BLOOD TEST MUST BE DONE 30 DAYS AFTER COMPLETING SERIES, NO EARLIER
Anti-HBs: Date (yy-mm-dd)____/____/____ Result:_____IU/ml If ≥than 10IU/L **no further action**
If <than 10IU/L **no further vaccination**

Attesting Signature of Health Care Professional (HCP)	
Name:_____ Signature:_____ Title:_____ Date (yy/mm/dd):_____/ _____/_____	Stamp:

Please email this form to your corresponding Clinical Placement Risk Management Advisor at the University of Ottawa.