DENTAL/MEDICAL ASSOCIATES, INC.
P.O. Box 273
White Marsh, MD 21162

EMPLOYEE IMMUNIZATION STATUS

Employee:_____

SS#:_____

Date of Employment:_____

	HBV Vaccination Date Series Completed
	Type Vaccine Used
HBV Booster	(as indicated) Date given
HBV Immune Status	(if known)

_____

Signature of Employee Date

_____

Supervisor Signature Date

Include in Employee Medical Record