ACADEMY OF
ALLIEDHEALTHSCIENCES

(973) 732-4179
(973) 732-4180
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24 Commerce Street, Federal Trust Bldg, Suite #504/510, Newark, New Jersey 07102

HEPATITIS B VACCINATION VERIFICATION

Student's Name: _____ **Date:** _____

Address: _____

Social Security Number: ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Select the program that the student is enrolled in:
(Please circle the program)

Medical Assisting
Medical Billing and Coding
Phlebotomy Technician
EKG- Electrocardiograph Technician
Medical Billing and Coding

Please list dates:
(If only part of the three series injections were given, please indicate only those dates. As the student completes the series submit verification on office letterhead or prescription pad)

1st Injection _____ 2nd Injection _____ 3rd Injection _____

If a **TITER TEST** was given, please list date and send results:

Date of Booster/Titer Test: _____

If medical contra-indication, the reason is: _____

Physicians Please Print:

Doctor's Name: _____ Office Number _____ Fax Number _____

Address: _____

Physician's Signature _____