



# TITER DECLINATION

NAME: \_\_\_\_\_

Please submit titers with proof of immunity for MMR, Chicken Pox/Varicella, and Hepatitis B. If you have declined to be vaccinated for any of the following items, please sign where indicated.

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**MMR** I am aware that in accordance with OSHA recommendation, hospitals are requiring a current MMR titer or record of a titer drawn in my profile prior to reporting to work. I hereby request a waiver, by signature, due to the possibility of adverse reactions to the live virus. I am aware that I am obligated to inform PRN Consultants and/or institution if I have been exposed to the virus and I am also aware that I will be unable to work for 21 days after exposure.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

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**CHICKEN POX/  
VARICELLA** I am aware that in accordance with OSHA recommendation, hospitals are requiring a current Varicella titer or record of a titer drawn in my profile prior to reporting to work. I hereby request a waiver, by signature, due to the possibility of adverse reactions to the live virus. I am aware that I am obligated to inform PRN Consultants and/or institution if I have been exposed to the virus and I am also aware that I will be unable to work for 21 days after exposure.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

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**HEPATITIS B** I understand that as a healthcare professional there is the potential for exposure to blood or other potentially infectious materials and that I may be at risk of acquiring Hepatitis B virus (HBV) infection. However, I decline receiving this vaccination. I continue to be at risk of acquiring hepatitis B, a serious disease.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

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**INFLUENZA** I understand that as a healthcare professional there is the potential for exposure to influenza. However, I hereby request a waiver by signature, due to the possibility of adverse reactions to the live virus.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_