PROOF OF HEPATITIS B COURSE + BOOSTERS

Candidate Personal Information			
Title: Mr, Mrs, Ms, Miss, Dr	Surname	First names	DOB
Home Tel:	Work Tel:	Mobile:	
Home Address:	GP Address:		

Hepatitis B history (THIS SECTION TO BE COMPLETED BY PHYSICIAN OR HEALTH PRACTIONER ONLY)	
Date of inoculation	Administer by (*if known*)

Boosters required /due (THIS SECTION TO BE COMPLETED BY PHYSICIAN OR HEALTH PRACTIONER ONLY)	
Result:	Date Obtained:

Please note;
we still require serological (pathology report) evidence of immunity to Hepatitis B

I hereby confirm that the information detailed with this form is present and correct		
Name:		Occupational Health Department / Surgery Stamp
Date:		
Signature		
GMC/ NMC or other clinical regulated body Ref. No.		**Please note a stamp is required for this form to be deemed valid**

***Please note this form is purely designed to obtain appropriate evidence for our screening process this in no way makes us liable for cost incurred for completing this form or any other forms that we may issue. ***