

**SOUTHWEST COOK COUNTY COOPERATIVE
ASSOCIATION FOR SPECIAL EDUCATION**

* To be completed by the Program Supervisor

Request for Hepatitis B Vaccine

To the Executive Director:

Please consider this request for the following Cooperative staff member to receive the hepatitis B immunization series:

(Name) _____ **(Position)** _____

(Program) _____ **(Location)** _____ **(District)** _____

Reason for Request: _____

Signature of Cooperative Supervisor Date

PLEASE PRESENT THIS FORM TO NURSE WHEN RECEIVING 1ST INOCULATION

FOR OFFICE USE

To: Nurse Coordinator

Billing Instructions: _____

Remarks/Comments:

If billed to Southwest Cooperative, Account Number

is: _____

9/04

CC: Employee

Orig: Personnel File
