THE FAITH FOUNDATION LLC

EMERGENCY CONTACT INFORMATION

EMPLOYEE

Full Name: _____
Last *First* *M.I.*

EMERGENCY CONTACT

Full Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Primary Phone/type: _____ Alternate Phone/type: _____

Relationship: _____

EMERGENCY CONTACT

Full Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Primary Phone/type: _____ Alternate Phone/type: _____

Relationship: _____

PHYSICIAN'S CONTACT INFORMATION

Doctor: _____ Practice: _____

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: _____ Fax: _____

NON-DISCLOSURE AGREEMENT

Employee_____
(Please Print)

I understand and agree that in the performance of my duties at The Faith Foundation LLC, I may be privy to confidential information about the organization and its operation. If at any time, I disclose trade secrets or confidential business information either intentionally or involuntarily, I will be terminated immediately even if I do not actually benefit from the disclosed information.

In addition, I will be subject to prosecution for theft of intellectual property and any other applicable charges which may result in imprisonment and/or fines should information be disclosed after employment is terminated. This agreement has no termination date.

_____ _____
Employee's Signature Date

THE FAITH FOUNDATION, LLC

Hepatitis B Vaccination Consent/Waiver Form
Complete only one section (A, B, or C)

NAME (PLEASE PRINT): _____

DATE OF BIRTH: _____

SSN: _____

Section A. **Consent for Hepatitis B Vaccine**

I, _____, consent to be immunized against Hepatitis B. I acknowledge the following.

1. I have been informed that I am at risk of acquiring hepatitis B because of the nature of my professional responsibilities.
2. I have read the information sheet that lists the indications, benefits, and presently known side effects of hepatitis B vaccine, have had an opportunity to ask questions, and have had them answered to my satisfaction.
3. I must receive three (3) doses of vaccine over a period of six (6) months to confer optimal immunity.
4. I understand, however, as with all medical treatment, there is no guarantee that I will become immune or that I will not experience an adverse reaction to the vaccine.
5. In the event that I experience any adverse side effects or do not become immune from the vaccine I hereby hold Northwestern University harmless from any and all liability to the extent permitted under the law.
6. In the event that I should terminate employment at The Faith Foundation prior to receiving all three (3) doses of the Hepatitis B vaccine, I understand that it will be my responsibility to complete the vaccination series on my own initiative and at my own expense.

_____ _____
Employee Signature Date

Are you currently pregnant or breast feeding? Yes ☐ No ☐ Dose/site/Lot#/Initials:

_____

Section B. **Previous Immunization with Hepatitis B Vaccine**

I, _____, have previously completed a three-dose series of the Hepatitis B Vaccine in (year)_____.

_____ _____
Employee Signature Date

_____

Section C. **Refusal to Receive Hepatitis B Vaccine**

I, _____, understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to myself. However, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

_____ _____
Employee Signature Date