↓↓↓ Non-Responder Form – ONLY if Repeat Titer(s) Negative ↓↓↓

Note to Provider: This form is only to be used in cases where the individual was fully immunized, has a negative/equivocal primary titer, and receives at least one booster but, despite repeat immunization, has a negative/equivocal repeat titer.

Note to Student: This form must be submitted to ADB/Complio using the corresponding category/requirement. For the form to be approved, you must document all preceding steps including negative/equivocal primary titer, booster(s) at appropriate intervals, and negative/equivocal repeat titer. Your program will be notified of your non-responder status so that your clinical/field placement agency can be notified as appropriate.

Part One – To be completed by provider

Please check immunization(s) for which individual is considered a non-responder:

- ☐ **Measles/Rubeola** – Individual has received full MMR series, primary IgG titer was negative/equivocal, individual received at least one MMR booster, and repeat IgG titer was negative/equivocal.
- ☐ **Mumps** - Individual has received full MMR series, primary IgG titer was negative/equivocal, individual received at least one MMR booster, repeat IgG titer was negative or equivocal.
- ☐ **Rubella** - Individual has received full MMR series, primary IgG titer was negative/equivocal, individual received at least one MMR booster, repeat IgG titer was negative/equivocal.
- ☐ **Varicella** – Individual has received full Varicella series, primary IgG/ACIF titer was negative/equivocal, individual received at least one Varicella booster, repeat IgG/ACIF titer was negative/equivocal.
- ☐ **Hepatitis B** – Individual has received full Hep B series, primary HBsAb (surface antibody) titer was negative/equivocal, individual received full repeat series (3-shot or 2-shot), repeat HBsAb titer was negative/equivocal.

By signing below, I certify that I have counseled the individual regarding their non-responder status including susceptibility to the disease(s) checked above, precautions to minimize potential exposure, and the need for medical evaluation if exposure occurs.

Provider Signature: _____ **Date:** ____/____/____ **Phone:** _____

Provider Name (printed): _____ **Address/Stamp:** _____

Provider Type: ☐ MD ☐ DO ☐ APRN ☐ PA _____

Part Two – To be completed by student

Please review carefully and check the appropriate statement(s) based on the immunization(s) for which you are considered a non-responder:

- ☐ **Measles, Mumps, Rubella, and/or Varicella** – I understand that I will not be allowed to provide direct care for patients with known active infections of a disease to which I am not immune. If it is discovered that I have been exposed to a disease to which I am not immune, I understand that I will not be able to attend clinical/field placement until I have provided negative serological results after the contagious phase of the incubation period for the disease.
- ☐ **Hepatitis B –** I understand that avoiding exposure to blood is the primary way to prevent transmission of Hepatitis B. Methods to minimize risk of such exposure include proper use of personal protective equipment (PPE); observance of aseptic technique; use of sterile, single-use, disposable needles and syringes; prompt and proper disposal of sharps via sharps containers, etc. If I am exposed to blood or body fluid that is positive or potentially positive for hepatitis B surface antigen, I understand that I should immediately seek medical care so that I may be treated with Hepatitis B immune globulin (HBIG) post- exposure prophylaxis to minimize risk of disease.

By signing below, I certify that I have reviewed the above information and understand my status as a non-responder for the immunization(s) indicated by my healthcare provider in Part One above.

Student Signature: _____ **Date:** ____/____/____

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