INFLUENZA VACCINATION DECLINATION FORM

EMPLOYEE INFORMATION

Employee Name:	Date of Birth:	
Employee Address:		
City:	State:	Zip Code:
Phone Number:	J#:	
Email:	Department:	

FACILITY

☐ University Hospital
☐ Providence Hospital
☐ Children's & Women's Hospital
☐ Mitchell Cancer Institute
☐ Physician Enterprise
☐ Other: _____

INFLUENZA VACCINATION STATUS AND ATTESTATION

I acknowledge that USA Health System recommends an annual influenza vaccination for healthcare personnel based on CDC and occupational health guidance, regulatory standards, and applicable law.

I have been provided education regarding the benefits and risks of receiving an annual influenza vaccine. I understand the risks of not receiving the vaccine this season and I had the opportunity to ask questions regarding influenza vaccination. I understand that declining influenza vaccination does not eliminate my responsibility to comply with USA Health System infection prevention and control recommendations. I was provided the opportunity to receive the current seasonal influenza vaccine through USA Health or another authorized vaccination provider; however, I am declining influenza vaccination for the reason identified below.

☐ Medical Exemption/Contraindication (e.g., history of severe allergic reaction to an influenza vaccine)
☐ Religious Accommodation Request (e.g., a component of the influenza vaccine conflicts with a religious belief)
☐ Personal Choice/Other Declination (e.g., personal preference due to concerns regarding the vaccine)

Employee Signature: _____ Date: _____

OCCUPATIONAL HEALTH USE ONLY

☐ Alternative infection prevention recommendations reviewed (masking guidance and patient care recommendations).

☐ Occupational Health RN or Designee Signature: _____