HEALTH CARE PERSONNEL INFLUENZA VACCINATION FORM

I am a VA: ☐ Employee ☐ Volunteer ☐ Other (ex: Trainee, Resident, Intern, Fee Basis, or Researcher)

Please indicate: _____

CHECK ONE STATEMENT BELOW AND COMPLETE AND SIGN THE LAST SECTION OF THIS FORM PRIOR TO SUBMISSION TO EMPLOYEE OCCUPATIONAL HEALTH:

☐ I received the seasonal influenza vaccine this flu season (required documentation is attached.)

☐ I have been granted a medical exemption from receiving the seasonal influenza vaccine this flu season. I have a contraindication for flu vaccine as defined by CDC. The reasons for contraindication must be recognized contraindications and precautions by the Centers for Disease Control and Prevention, found here: https://www.cdc.gov/flu/prevent/whoshouldvax.htm. This has been discussed and acknowledged by my personal physician. I understand that by declining to receive the vaccine by November 30 or within two weeks of beginning employment, I must wear a face mask according to requirements and guidelines within VHA Directive 1192.01, Seasonal Influenza Vaccination Program for VHA Healthcare Personnel.

_____
Printed Physician Name and Address

_____ _____ _____
Physician Signature | Date | National Provider Identification Number

_____ _____ _____
Supervisor Signature | Date | Supervisor Email

☐ I notified my immediate supervisor in writing that I have a deeply held religious belief that prevents me from receiving the seasonal influenza vaccine this influenza season. I understand that by declining to receive the vaccine by November 30 or within two weeks of beginning employment, I must wear a face mask according to requirements and guidelines within VHA Directive 1192.01, Seasonal Influenza Vaccination Program for VHA Healthcare Personnel.

_____ _____ _____
Supervisor Signature | Date | Supervisor Email

I have read and fully understand the information on this form and have been given the opportunity to have my questions answered. I understand that violation of the directive may result in disciplinary action up to and including removal from federal service.

Name (print): _____ Last 4 SS#: _____ Dept./Serv: _____

Employee Signature: _____ Date: _____

Employees and volunteers provide this form to the VHA facility Employee Occupational Health Office. Health Professions Trainees provide this form to the Designated Education Officer. Secure electronic submission is permissible.