

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 (any 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 Health Care 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 Health Care 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.