6.1.23

COVID-19 Vaccine Declination

PLEASE COMPLETE THE FOLLOWING INFORMATION:

Full Name:	**Date of Request:**
Employee ID #:	**Phone number:**
Date of Birth:	**Location/Department/Title:**
Email address:	**Manager:**

Do you work in an Inpatient Rehab unit/facility that is part of this facility? ☐ Yes ☐ No

Do you work in an Inpatient Psychiatric Unit/facility that is part of this facility? ☐ Yes ☐ No

Your position at the facility:

☐ Employee (staff on facility payroll) ☐ Licensed independent practitioner ☐ Adult student/trainee/volunteer

☐ Contract personnel (outsourced EVS, dialysis, etc.) ☐Other _____

I am declining the COVID-19 vaccination for one of the following reasons: *Check if applicable*

☐ **Medical contraindications**: Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a component of the COVID-19 vaccine or an immediate allergic reaction of any severity to a previous dose or known (diagnosed) allergy to a component of the vaccine

☐ **Other**

***Please do not provide any further documentation or explanation at this time.

By signing below, I verify that the above information is complete and accurate and affirm my understanding that providing false or misleading information on this, or any other employment document is a violation of company policy that could result in discipline up to and including termination. I understand that the company may have to take additional safety precautions and require additional safety protections in relation to my employment.

Signature: _____ Date: _____