

All applicants must complete either the Attestation or the Declination

Attestation of Influenza Vaccination

By my signature below, I attest that I have received the 2010 influenza vaccination from a provider other than Providence.

Vaccination Clinic Location _____ Vaccination Date _____

Practitioner Signature _____ Signature Date _____

Practitioner Name (print) _____

Declination of Influenza Vaccination

My Medical Staff Leadership has required that I receive influenza vaccination to protect the patients I serve, my colleagues, my family and my community. I acknowledge that I am aware of the following facts:

- Influenza is a serious respiratory disease that kills an average of 36,000 persons and hospitalizes more than 200,000 persons in the United States each year.
- Influenza vaccination is recommended for me and all other healthcare workers to protect our patients and colleagues from influenza disease, its complications, and death.
- If I contract influenza, I will shed the virus for 24–48 hours *before* influenza symptoms appear. Shedding the virus can spread influenza disease to all people with whom I come in contact or those in close proximity to me.
- If I become infected with influenza, even when my symptoms are mild or non-existent, I can spread severe illness to others.
- I understand that the strains of virus that cause influenza infection change almost yearly, which is why a different influenza vaccine is recommended each year.
- I understand that I cannot get influenza from the influenza vaccine.
- The consequences of my refusal to be vaccinated could have life-threatening consequences to my health and the health of those with whom I have contact, including my patients and other patients in this healthcare setting, my coworkers, my family and my community.

Despite the information provided I am choosing to decline influenza vaccination right now. I understand:

- I may change my mind at any time and accept influenza vaccination, if vaccine is available
- I will be required to wear a face mask at all times when on the premises of any Providence Regional Medical Center Everett facility during the time period the Snohomish County Health Officer declares that influenza is active in the community. I understand that my mask may be removed during meal and rest breaks to allow me time to eat and drink without hindrance.
- I will need to notify Medical Staff Services if I received an influenza vaccination at a different location.

Regarding my decision not to receive an influenza vaccination, I understand:

- Any medical information provided via this declination will be held in my Providence Medical Staff file and will only be shared Providence Employee Health & Wellness.
- I will not be allowed to be present on any Providence premises if I refuse to receive an influenza vaccination and refuse to wear a face mask while on the premises. This will be in effect during the time period that the Snohomish County Health Officer declares that influenza is active in the community.

Vaccine Status:

- I am declining to receive the influenza vaccination due to medical contraindications
- I am declining to receive the influenza vaccination due to religious or philosophical objections
- Other (specify) _____

I have read, fully understand and will comply with the requirements on this declination form.

Signature _____ Date _____

Practitioner (print) _____ Practitioner # _____