



Request for Exemption from Influenza Vaccination

Type of Exemption requested: **Medical**

Attach a physician statement to this form

Religious/Moral/Ethical

Attach a signed statement to this form

Request previously submitted

Printed Name: _____ Phone #: _____

Email: _____ Facility: _____

Department/Unit: _____ Supervisor: _____

As a patient safety initiative, University Medical Center requires influenza vaccinations for all of its employees, physicians, volunteers, students and contract workers similar to other required vaccinations (such as MMR and varicella).

For decades influenza vaccination has been recommended for healthcare workers and has been shown to be effective in protecting patients.

I acknowledge that I am aware of the following facts:

- **Influenza vaccination is recommended by the CDC for all healthcare workers to protect patients by preventing influenza disease and its complications, including death.**
- **If I contract influenza, I can shed the virus for 24-48 hours before influenza symptoms appear. Shedding the virus can spread influenza infection to patients and others in this facility.**
- **If I become infected with influenza, even when my symptoms are mild, I can spread severe illness to others. I understand that I should not work when ill, especially if illness includes a fever. A mask should be used with any respiratory illness.**
- **I am aware that I will be required to wear a mask when providing direct patient care, if I anticipate being within 6 feet of a patient or if the distance is greater than 6 feet but the exposure to a patient is prolonged.**
- **I will wear a sticker on my badge that indicates my need to wear a mask.**
- **The strains of virus that cause influenza infection change almost every year, which is why a different influenza vaccination is recommended each year.**
- **The influenza vaccine is an inactivated virus and cannot give me the flu.**
- **The consequences of my refusing to be vaccinated could endanger my health and the health of those with whom I have contact, including patients in this healthcare facility, my coworkers, my family, and my community.**
- **Non-compliance with this policy may result in disciplinary action.**

Despite these facts, I am requesting exemption from influenza vaccination. I understand that I can change my mind at any time and accept influenza vaccination, if the vaccine is available.

I have read and fully understand the information on this form.

PRINTED Legal Name: _____

Signature: _____ Date _____