Immunization Declination Form

I understand that my exposure to patients at healthcare facilities with the following vaccine-preventable diseases puts me at risk of acquiring the disease. I have had the opportunity to be vaccinated, however, I choose to decline the vaccination(s) checked below at this time. I understand that by declining vaccine protection I continue to be at risk of acquiring the disease.

In the event of exposure I understand that I may be requested to not visit the facility for at least the incubation period of the disease to which I have been exposed. In some cases that may be for a period of up to a month.

Type	Reason
☐ Measles, Mumps, Rubella (MMR)	_____
☐ Varicella (VZW)	_____
☐ Hepatitis B	_____
☐ Influenza	_____
☐ H1N1	_____
☐ Tetanus / Pertussis / Tdap	_____
☐ TB ☐ Chest X-Ray	_____
☐ Other _____	_____

By submitting this form, I acknowledge that each of my customers defines the required documentation used to manage vendor relationships, and that a vaccination declination may not satisfy these requirements.

Signed: _____ Date: _____

Printed Name: _____ Title: _____

Company: _____ Phone #: _____