Declination Form

I understand that my exposure to patients at healthcare facilities with the following diseases puts me at risk of acquiring the disease. Most of these diseases are preventable through vaccines. I have had the opportunity to be vaccinated for these diseases; however, I choose at this time to decline the vaccination(s) checked below. I understand that by declining vaccine protection I continue to be at risk of acquiring the disease. I understand that I can receive these vaccinations or tests at any time.

VACCINATION OR TEST	REASON
☐ Measles, Mumps, Rubella (MMR)	_____
☐ Varicella	_____
☐ Hepatitis B	_____
☐ Influenza	_____
☐ Pertussis	_____
☐ Tuberculosis (either test or chest x-ray)	_____
☐ Other: _____	_____

☐ By submitting this form, I acknowledge that each of the healthcare facilities defines the required documentation used to manage healthcare staffing relationships and that a declination may not satisfy these requirements.

Name: _____ **Date:** _____

Phone #: _____