Influenza Vaccine Declination Form

In order to ensure your privacy and confidentiality,
Please return this form directly to Employee Health & Wellness.

Please retain a copy of this form for your records.
2024-2025 Flu Season

Name:		SB ID#:	
DOB:		Job Title:	

I understand that due to my possible contact with patients, I am at risk for contracting and/or transmitting influenza to patients and/or other healthcare workers. I have been given the opportunity to receive the influenza vaccine recommended for healthcare workers by the CDC and I am declining this vaccine.

I understand that by declining this vaccine **I will be required**, by NYS DOH Section 2.59 of NY Codes Rules and Regulations Title 10, **to wear a mask** throughout the entire flu season while working in areas where patients may be present. I understand that failure to comply with this requirement will result in referral to Labor Relations for appropriate administrative action.

I also understand that if I am a "Hospital Access Employee", I remain eligible to receive the vaccine at no charge until the end of the current flu season if supplies are still available.

Please read below and check all that apply:

I decline the vaccination for the following reason(s):

	I believe I will get the flu if I get the flu shot.
	I do not like needles.
	I have a medical contraindication to receiving the vaccine.
	I do not wish to share my reason for declining.
	Other:

Signature:		Date:	

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