

INFLUENZA VACCINATION EXEMPTION REQUEST FORM

NAME: _____ Date of Birth: ____ / ____ / ____

JOB TITLE: _____

DEPARTMENT: _____ MANAGER: _____

I request an exemption to the MedStar Mandatory Influenza Vaccination requirement based on the following:

_____ MEDICAL CONTRAINDICATION TO THE INFLUENZA VACCINE

_____ RELIGIOUS OBLIGATION/RESTRICTION

I have attached and/or requested the required supporting documentation as outlined in Hospital Policy #505 Mandatory Flu Vaccination to this request. I understand that my failure to submit acceptable medical documentation or information demonstrating my religious basis for an exemption before the end of the Designated Vaccination Period may result in my request for an exemption being denied.

My signature on this form is my attestation that I am requesting an exemption in good faith, and the information I am providing or causing others to provide on my behalf is true and correct. I understand that providing false or misleading information may be grounds for discipline up to and including discharge.

I understand and consent to the following:

- My exemption request will be reviewed by the Designated Office at my site.
- My manager and/or supervisor also may be consulted as part of the exemption review process.
- My manager and/or supervisor will be notified if I am granted an exemption.
- My exemption may not be granted if it would pose a direct threat to others (i.e., patients, co-workers, or visitors) or if it would otherwise create an undue hardship on MedStar Health.

Signature: _____ Date: _____

RETURN FORM(S) TO OR FAX:

- If you are an Employee, Board Member, Volunteer return or fax to Employee Health Services, fax 202-444-6009
- If you are a Medical Staff member, Credentialed Professional, or Licensed Individual Practitioner return or fax to Medical Staff Office, fax 202-444-2316
- If you are a Housestaff member or Medical Student return or fax to Graduate Medical Education, fax 202-444-4859
- If you do not fit any category mentioned above return or fax to Employee Health Services, fax 202-444-6009

DESIGNATED OFFICE USE ONLY:

Medical Documentation Received on: _____ Religious Exemption Approved on: _____

Approving Staff Signature: _____ DATE: _____

Denial Staff Signature; _____ DATE _____

Manager Notified on date: _____