**COVID-19 VACCINATION DECLINATION FORM**

**I HEREBY ACKNOWLEDGE THAT:**

• COVID-19 is a highly contagious and potentially fatal respiratory disease that has killed roughly 300,000 Americans to date.

• The SARS-CoV-2 virus that causes COVID-19 may be shed for up to 48 hours before symptoms begin, increasing the risk of transmission to others.

• Some people with COVID-19 have no symptoms, increasing the risk of transmission to others.

• COVID-19 vaccine cannot transmit COVID-19 and it does not prevent all disease.

• I have declined to receive the COVID-19 vaccine.

\* I acknowledge that COVID-19 vaccination is recommended by the U.S. Centers for Disease Control and Prevention for all healthcare workers in order to prevent infection from and transmission of COVID-19 and its complications, including death, to patients, my co-workers, my family, and my community.

• I am required to wear a mask at all times while in any XYZ Laboratories clinical area during the pandemic as defined by the Chief Medical Officer.

• My supervisor and manager, including division and departmental leadership will be notified that I declined.

PRINT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Knowing these facts, I choose to decline vaccination at this time. I may change my mind and accept vaccination later, if vaccine is available. I have read and fully understand the information on this declination form. I decline vaccination for the following reason(s). (Please list)

Print Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_

Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Department \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Manager’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_