



## Declination Form For COVID-19 Vaccination

Name (printed): \_\_\_\_\_ EEID#: \_\_\_\_\_ DOB: \_\_\_\_\_

McLaren Facility Location: \_\_\_\_\_ Please Check One:  Employee  Non-Employed Provider  
 Contractor  Volunteer/Student

My employer, McLaren Health System, has highly recommended that I receive the COVID-19 vaccination, per CDC recommendations, to prevent infection from and transmission of SARS-CoV-2 and its complications, including death, to my patients, my coworkers, my family, and my community.

**I acknowledge that I am aware of the following facts (please read and check each box):**

- COVID-19 is a serious respiratory disease that can easily spread from person to person.
- COVID-19 vaccination is recommended for me and all other healthcare workers to prevent COVID-19 disease and its complications, including death.
- If I contract COVID-19, I am potentially contagious for 2 days before any symptoms appear and for 10-14 days after infection.
- If I become infected with COVID, I will be required to isolate away from others and will not be able to work for a minimum of 5 days after symptoms appear or 5 days from the date of a positive test if I have no symptoms. Upon return to work, I will be required to wear a medical grade mask for 5 additional days.
- I understand that I cannot get COVID-19 from the vaccine and getting the vaccine is a safer way to build up protective immunity.
- The consequences of my refusal to be vaccinated could endanger my health and the health of our patients, my family, my coworkers, and my community.

**Despite these facts, I am choosing to decline COVID-19 vaccination at this time.**

- I understand that by declining this vaccine I am at risk for acquiring COVID-19, potentially resulting in transmission to others. If required, I attest that I will wear a mask at all times in all areas of the hospital except in staff break rooms, conference rooms or within private offices as allowed by the office occupant. I understand that mask use may be required at all times during the peak respiratory virus season from December through May per MHC policy.

I understand I may change my mind at any time and accept the COVID-19 vaccination if vaccine is available.

**I have read and fully understand the information on this declination form.**

**\*\*\*Please specify the reason for declination:**

- Severe life threatening allergies to components of the vaccine.
- History of Guillain-Barre Syndrome within 6 weeks following a prior immunization
- I do not believe in the vaccine for religious reasons.
- Other reason (please provide explanation here): \_\_\_\_\_

**OR**

\_\_\_\_ I attest that I have been vaccinated against COVID-19 as defined by current CDC recommendations for healthcare workers  
(Please provide proof of vaccination to employee health or check box below to give permission to employee health staff to access your MCIR to verify vaccination)

\_\_\_\_ I agree to have my immunization records accessed through the Michigan Care Improvement Registry (MCIR)