Updated 9/14/2023

Declination Form For COVID-19 Vaccination

Name (printed):______________________ EEID#:__________________ DOB:______________

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

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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)**

______________________________ ______________________
Signature **Date Signed**