*APPENDIX 1: VACCINE DECLINATION FORM

INFLUENZA VACCINE DECLINATION STATEMENT

Please print information below:

Employee Name: ______________________ Date of Birth: ___/___/___ Title/Position:________________

Department: __________________________Supervisor:______________________ Personal Phone #: ____________

PLEASE CIRCLE ONE: EMPLOYEE JHLAB MD/PA/ALLIED HEALTH VOLUNTEER AGENCY

CONTRACTUAL-BROADWAY CONTRACTUAL-DIETARY OTHER:___________________

Declination of Annual Influenza Vaccination:

- I understand that due to my occupational exposure, I may be at risk of acquiring infection. In addition, I may spread influenza to my patients, other healthcare workers, and my family, even if I have no symptoms. This can result in serious infection, particularly in persons at high risk for influenza complications.
- I have received education about the effectiveness of the influenza vaccination as well as the adverse events. I have also been given the opportunity to be vaccinated with influenza vaccine, at no charge to myself. However, I decline influenza vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring influenza, potentially resulting in transmission to my patients. If in the future I want to be vaccinated with influenza vaccine, I can receive the vaccine at no charge to me.
- I attest that I will wear a mask anytime I am within six feet of a patient for the duration of the influenza season if I do not receive the influenza vaccination.

Reason for declining: **(Please check all that apply.)**

___ **I received the vaccine from another facility (Documentation must be provided to Occupational Health or Medical Staffing Office for Professional Staff.)**

___ **I request a medical exception (The Medical Exception Form must be completed and returned to Occupational Health.)**

___ **I request a religious accommodation (The Religious Accommodation Form must be completed and returned to Human Resources.)**

Please send this form to Howard County General Hospital:

Employees and Volunteers:	Professional Staff and Allied Health:
Howard County General Hospital Occupational Health 5755 Cedar Lane Columbia, MD 21044 Office: 410-740-7838 Fax: 410-740-7685 Occupationalhealth@hcgh.org	Howard County General Hospital Medical Staffing Services 5755 Cedar Lane Columbia, MD 21044 Office: 410-740-7544 Fax: 410-740-7561

Employee **Signature:**____**Date:**__________

DESIGNATED OFFICE USE ONLY

Declination Statement Received On: ___/___/_____ Approving Staff Signature: _____________________________

*APPENDIX 2: CRITERIA FOR MEDICAL EXCEPTION

Medical exceptions include:

1. Severe allergy to eggs or vaccine components;
2. Guillian-Barré within six (6) weeks of receiving an influenza vaccine.

OHS will evaluate the allergy history and determine a course of action based on severity.

- Individuals who report non-severe reactions to egg (e.g., hives) may have influenza vaccine if additional measures are taken.
- Those patients who are able to eat eggs, cake or foods with egg protein without reaction may receive the vaccine.
- Individuals who have experienced less severe reactions to egg (hives only) may receive influenza vaccine with the following additional measures:

    1. Killed influenza vaccine formulation (TIV) should be used; preferably vaccines with less than 0.12 mcg of egg protein should be administered.
    2. Patients should be observed for 20-30 minutes for signs of a reaction following administration of each vaccine dose.

If OHS determines that there is a history of a severe allergic reaction to the vaccine or its components, an allergy consultation can be offered. (Other measures, such as dividing and administering the vaccine by a two-step approach and skin testing with vaccine are not necessary.) This should include persons who report having had serious reactions to egg involving such symptoms as angioedema, respiratory distress, lightheadedness, or recurrent emesis; or, who required epinephrine or other emergency medical intervention, particularly those that occurred immediately or within a short time following egg exposure (minutes to hours), are most likely to have a serious systemic or anaphylactic reaction upon re-exposure to egg proteins. Prior to receipt of vaccine, such individuals will be referred to an allergy specialist for further risk assessment. Preferably vaccines with less than 0.12 mcg of egg protein should be administered.

If the patient reports a history of Guillian-Barré from any cause in the past six (6) weeks, the individual may be referred to a neurologist with expertise in this area.

Request for Medical Exception from influenza Vaccination

Please print information below:

Employee Name:______________________ Date of Birth:________/____/________

Employee E-mail:_____________________ Personal Phone #:__________________

Department:__________________________ Manager:_________________________

Physician Name:______________________ Physician Phone #:_________________

Dear Physician:

Howard County General Hospital requires influenza vaccination similar to other required vaccinations such as MMR and varicella. For decades influenza vaccinations have been recommended for healthcare workers because they have been shown to be effective in reducing the incidence of influenza in inpatient populations. Influenza vaccination has also been recommended for pregnancy by the Centers for Disease Control to protect pregnant women (who are at increased risk of severe disease) and to protect the baby after it is born. The above named employee is requesting an exception from this vaccination requirement. A medical exception from influenza vaccination is allowed for certain recognized contraindications (CDCMMWR Early Release 2011; Vol. 60. Available online: http://www.cdc.gov/mmwr/pdf/wk/mm60e0818.pdf . Please complete the form below. Should you have any questions, please contact Occupational Health Services at 410-740-7838. Thank you.

The above employee should not be immunized for influenza for the following reason:

- ☐ History of previous severe allergic reaction and documented allergy testing to indicate an immediate hypersensitivity reaction to the influenza vaccine or a component of the vaccine (including egg allergies).
- ☐ History of Guillain-Barre Syndrome within six weeks of receiving a previous vaccine. Please provide a detailed narrative that describes the event.
- ☐ Other – Please provide this information in a separate narrative that describes the exception in detail (these requests will be reviewed on a case-by-case basis).

I certify that ______________________________________has the above contraindication and request a medical exception from the influenza vaccination.

Physician Signature:___________________________________Date:_____________________

Physician Medical License Number:_____________________________

DESIGNATED OFFICE USE ONLY:

Medical Exception Approved On:_____/______/______ Approving Staff Signature:______________________________

Request for Religious Accommodation Related to Flu Vaccine

Howard County General Hospital is committed to diversity and inclusiveness of all our employees. To consider your request for a religious workplace accommodation, please provide the following information:

Part 1 – To Be Completed by Employee (additional sheets may be used, if necessary)

Name: ____ **Date of Request:**____________________________

Department: ______________________ **Manager:** ____

Reason for Request:

____

____

____

Suggested reasonable accommodation to meet your requirements or limitations:

____

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____

If you have requested this religious accommodation before, please state approximately when the prior request was made, the name of the individual who responded and the outcome of the request:

____

____

Religion Tenet(s) Documentation

In some cases, HCGH will need to obtain documentation or other authority regarding your religious practice or belief. We may need to discuss the nature of your religious belief(s), practice(s) and accommodation with your religion's spiritual leader (if applicable) or religious scholars to address your request for an accommodation.

If requested, can you obtain documentation or other authority to support the need for an accommodation based on your religious practice or belief?

Yes __________ No __________

Verification and Accuracy

I verify that the above information is complete and accurate to the best of my knowledge and I understand that any intentional misrepresentation contained in this request may result in disciplinary action.

I also understand that my request for an accommodation may not be granted if it is not reasonable or if it creates an undue hardship on my employer.

Signature: ____ Date: ________________

Print Name: ____

Summary of Next Steps

1. **This request will be completed by the employee requesting a religious accommodation.**
2. **You will submit your request to the Sr. Vice President, Human Resources no later than November 1st.**
3. **You will be notified of the decision and/or the proposed accommodation within thirty (30) days.**
4. **If you disagree with the decision or proposed accommodation, please contact the Department of Human Resources, Howard County General Hospital for assistance at 410-740-7851.**

Part 2 – To be completed by HR Representative

Interactive Discussion Date:

____

Employee's Suggested Accommodation: ____

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____

Results of Interactive Discussion: ____

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Evaluation of Impact (if any): ____

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Accepted: ______ **Not Accepted:** ______

If Not Accepted, Why? :

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____

____

Alternative Accommodations (list in order of preference):

1. ____

2. ____

3. ____

Effective Date of Accommodation: ________________________

Duration Period of Accommodation: ______________________

Document reason denying request for a reasonable accommodation: _________________________

____

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____

Department Head's Signature: _______________________________________**Date:** ______________

HR Representative: ____**Date:** _______________

cc: **Employee**
Employee's Manager/Director
Department of Human Resources, Howard County General Hospital