



JOHNS HOPKINS  
MEDICINE

**JOHNS HOPKINS VACCINE DECLINATION STATEMENT**  
**PLEASE PRINT THE FOLLOWING INFORMATION**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
E-mail: \_\_\_\_\_ Phone/Pager No.: \_\_\_\_\_  
Department: \_\_\_\_\_ Unit/Services Where You Work: \_\_\_\_\_  
Identification No. (JHED ID / Badge #): \_\_\_\_\_ Do you have any direct patient contact? YES  NO

[Note: direct patient contact is anyone working within 6 feet of a patient]

**Division**

JHH  JHU  SoM  SoN  BSoPH  JHCP  Bayview  Other  \_\_\_\_\_

**Employment Status**

Staff/Faculty  Student  Volunteer  Family Member  Contractor  Other  \_\_\_\_\_

**DECLINATION of Annual Influenza Vaccination:**

- I understand that due to my occupational exposure, I may be at risk of acquiring influenza 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 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 may be provided online or e-mailed/mailed/faxed to Occupational Health Services).
- I request a medical exception (The Medical Exception Form may be e-mailed/mailed/faxed to Occupational Health Services).
- I request a religious accommodation (The Religious Accommodation Form must be completed and returned to Supervisor).

**Employee Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**PLEASE FAX OR MAIL THIS TO OCCUPATIONAL HEALTH SERVICES**

East Baltimore Campus  
Johns Hopkins Medicine  
Occupational Health Services  
The Church Home Professional Office Building  
98 North Broadway, Room 421  
Baltimore, MD 21231  
Office 410.955.6211  
Fax 410.955.1617  
[ddooley3@jhmi.edu](mailto:ddooley3@jhmi.edu)

Homewood Campus  
The Johns Hopkins University  
Occupational Health Services  
3400 North Charles Street  
W-601 Wyman Park Building  
Baltimore, MD 21218  
Office 410.516.0450  
Fax 410.516.0452  
[cshopman@jhu.edu](mailto:cshopman@jhu.edu)

**DESIGNATED OFFICE USE ONLY:**

Declination Statement Received on: \_\_\_\_/\_\_\_\_/\_\_\_\_ Approving Staff Sig \_\_\_\_\_