HOSPITAL

MEDICAL STAFF OFFICE

Screening for Influenza Vaccination for Physicians

Name:	**Physician ID#:**		**Today's Date:**
Address:	**Office Phone:** ( )	**Office FAX:** ( )	

Attestation for Receipt of Influenza Vaccination

☐ I have received the influenza vaccine for the xxxx-xxxx season.

Setting where vaccine was administered:
☐ Hospital ☐ Clinic ☐ MD office ☐ Other

Attestation: Signature ________________________________

Declination

☐ I have declined to receive the influenza vaccine for the xxxx-xxxx season. I acknowledge that influenza vaccination is recommended by the CDC for all healthcare workers to prevent infection from and transmission of influenza and its complications, including death, to patients, my coworkers, my family, and my community.

Reasons for declination:

- ❑ I am allergic to components of the vaccine (specify) ________________
- ❑ I don't believe in vaccines.
- ❑ I won't take the vaccine because of side effects.
- ❑ I don't believe it is important.
- ❑ I never get the Flu.
- ❑ I have had Guillen Barre or other medical problems that preclude me from receiving the vaccine.
- ❑ I got severe influenza-like symptoms from the influenza vaccine and won't get it again.
- ❑ Other (specify)____

Attestation: Signature ________________________________

I authorize release of the information above to the Medical Staff Office and its agents for credentialing purposes only. This authorization is to be renewed annually and I understand that I may revoke this authorization in writing. I understand I have the right to receive a copy of this signed form.

Signature: ________________________ **Date:** ________________

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