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*Director*

State of California—Health and Human Services Agency  
California Department of Public Health



ARNOLD SCHWARZENEGGER  
*Governor*

August 29, 2008

AFL 08-17

**TO:** General Acute Care Hospitals

**SUBJECT:** New Regulatory Requirements for Compliance with Senate Bill 739 –  
Reporting of Influenza Vaccination/Declination of Employees and  
Healthcare Personnel

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Chief Executive Officer  
Chief Nurse Executive  
Quality Management Department  
Infection Control Committee Chair  
Infection Prevention and Control Professionals  
Employee Health Professionals

**Authority:**  
Senate Bill (SB) 739 (Speier, Chapter 526, Statutes of 2006)  
California Code of Regulations, Title 22, §70739

- Attachments:**
- A. Employee Influenza Vaccination/Declination Surveillance for Acute Care Hospitals, 2007-2008 Influenza Season
  - B. Sample 1: Influenza Vaccine Consent/Declination
  - C. Sample 2: Influenza Vaccine Consent/Declination
  - D. Sample: Influenza Information for Employees
  - E. National Healthcare Safety Network (NHSN) Pre-Season Survey on Influenza Vaccination Programs for Healthcare Personnel
  - F. NHSN Post-Season Survey on Influenza Vaccination Programs for Healthcare Personnel
  - G. NHSN Healthcare Personnel Safety Component Facility Survey
  - H. Sample: Attestation for Non-employee MDs

**Background:**

This is a follow-up letter to delineate new requirements for compliance with Health and Safety Code Section 1288.5 et. seq., the former Senate Bill 739. Please review and share this document with all persons in your facility responsible for infection prevention and control activities, employee health, and quality management reporting.

**Reporting of Influenza Vaccination/Declination Rates for Employees, 2007-2008 Influenza Season**

Each acute care hospital in California is requested to report influenza vaccination/informed declination rates for employees for the 2007-2008 influenza season and to submit this data to CDPH (see *Attachment A*) by September 30, 2008.

1. Employees are defined as all workers who collect their primary paycheck from your facility, whether or not they have patient contact.
2. The cutoff date for tabulation of the numerator (number of employees who received a vaccination at their facility or another facility) OR who signed a mandatory informed declination form (see *Attachments B and C as examples*) is March 31, 2008. The denominator is based on the total number of employees on March 31, 2008.
3. In addition to a vaccination/informed declination rate, each acute care hospital is requested to submit a vaccination rate (number of employees who received a vaccination at their facility or another facility) with total number of employees (using March 31, 2008 as the cut off date for numerator and denominator).

**Reporting of Influenza Vaccination/Declination Rates for Healthcare Personnel, 2008-2009 Influenza Season**

Beginning with the 2008-2009 influenza season, each acute care hospital shall take actions to ensure that all healthcare personnel are offered education on influenza and the opportunity to receive the influenza vaccine during the influenza season (between September 1, 2008 and March 31, 2009):

1. Education is required for employees regarding benefits of influenza vaccination and potential health consequences of influenza illness for employees and their patients. Education must also include the epidemiology, modes of transmission, diagnosis, treatment, and non-vaccine infection control strategies. Facilities may incorporate, the following components into the required influenza education offered prior to the healthcare worker signing a consent or informed declination:
  - a) Influenza is a serious respiratory disease that kills, on average, 36,000 Americans every year.
  - b) Influenza virus may be shed for up to 48 hours before symptoms begin, allowing transmission to others.

- c) Up to 30% of people with influenza have no symptoms, allowing transmission to others.
  - d) The vaccine cannot transmit influenza.
  - e) Despite an occasional mismatch of the vaccine with the circulating strains, vaccination offers **SOME** protection.
  - f) For those who fear injections, the intranasal vaccine (Flumist®) may be an option. (Please review CDC guidance on appropriate candidates.)
2. Incorporate the following phrase into all informed declination and attestation forms: “I have declined the influenza vaccination for the xxx influenza season. I acknowledge that influenza vaccination is recommended by the Centers for Disease Control and Prevention (CDC) for all healthcare personnel to prevent infection from and transmission of influenza and its complications, including death, to my patients, my coworkers, my family, and my community”.
3. Complete demographic data and submit to NHSN within 30 days of the end of the respective month of the reporting year, as required by CDC. (*Attachment E* is due by September 30. *Attachment F* is due by October 30. *Attachment G* is due April 30.) These forms are found in the NHSN Healthcare Personnel Influenza Vaccination module). Have employees complete informed declination forms only **during** the influenza vaccination season (September 1 through March 31 of the reporting season/year).
- 4.
- a) By September 1, 2008, each acute care hospital may develop a prioritized list of healthcare personnel not included in the facility’s roster of employees AND who have frequent patient contact . The purpose of this list is for the facility to develop a strategy that will culminate in 100% outreach to healthcare personnel (see definition in (d) below) with vaccination or informed declination of the annual influenza vaccine. Rates established during the 2008-2009 influenza season will establish baseline vaccination/informed declination rates to be improved upon in succeeding influenza seasons. Examples of Licensed Independent Practitioners (LIPs) who might be prioritized include emergency department physicians, intensivists, oncologists, cardiologists, hospitalists, and neonatologists. (*See Attachment H* as an example of an LIP attestation.)  
**OR**
  - b) Facilities may choose to report vaccination and informed declination rates for all healthcare personnel not included in “employees”, bypassing the step of making a prioritized list of non-employee healthcare personnel as per (a) above.

- c) As influenza vaccination of all healthcare personnel is recommended by the CDC, it is suggested that acute care hospitals establish a process ensuring that contract agencies provide evidence of influenza vaccination and/or verification of informed declination for all contracted healthcare personnel.
- d) The CDC defines healthcare personnel (HCP) as “all paid and unpaid persons working in healthcare settings who have the potential for exposure to infectious materials, including body substances, contaminated medical supplies and equipment, contaminated environmental surfaces, or contaminated air. HCP might include (but are not limited to) physicians, nurses, nursing assistants, therapists, technicians, emergency medical service personnel, dental personnel, pharmacists, laboratory personnel, autopsy personnel, students and trainees, contractual staff not employed by the healthcare facility, and persons (e.g., clerical, dietary, housekeeping, maintenance, and volunteers) not directly involved in patient care but potentially exposed to infectious agents that can be transmitted to and from HCP.” This definition is from: “Influenza Vaccination of Health-Care Personnel: Recommendations of the Healthcare Infection Control Practices Advisory Committee (HICPAC) and the Advisory Committee on Immunization Practices (ACIP)” guideline dated February 24, 2006. (<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5502a1.htm>).

5. Please note that any individual consent, declination, and attestation forms should be handled in a manner that assures individual confidentiality.

**Reporting of Influenza Vaccination/Declination Rates for Healthcare Personnel, 2009-2010 Influenza Season and Beyond**

Each acute care hospital shall, in accord with their strategic plan, increase vaccination/informed declination rates for each successive influenza season over prior baseline rates so as to eventually offer influenza vaccination to **all** employees and healthcare personnel within the given influenza season.

If you have questions about this All Facilities Letter, please contact Sue Chen, HAI Program Coordinator at [Sue.Chen@cdph.ca.gov](mailto:Sue.Chen@cdph.ca.gov) or phone (510) 620-3434.

Sincerely,

**Original Signed by Kathleen Billingsley, R.N.**

Kathleen Billingsley, R.N.  
Deputy Director  
Center for Healthcare Quality

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August 29, 2008

cc: California Hospital Association  
California Conference of Local Health Officers  
HAI Advisory Committee

Attachment A

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**Employee Influenza Vaccination/Declination Surveillance  
For Acute Care Hospitals**

**Data Collection Start Date: September 1, 2007; End Date: March 31, 2008**

**Name of Facility:** \_\_\_\_\_

**Facility NHSN ID#:** \_\_\_\_\_ (5 digits)

**Name of Person Completing Form:** \_\_\_\_\_  
Please print legibly

**Contact Information:**

**Email:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

Components	Number
1. Total number of employees (include part-time)	
2. Sum total number of vaccinations <sup>1</sup> and declinations	
3. Vaccination/declination rate (Item 2/Item 1)	(    %)
4. Total number of vaccinations <sup>1</sup>	
5. Vaccination rate (Item 4/Item 1)	(    %)

**Upon completion, please email this to [infectioncontrol@cdph.ca.gov](mailto:infectioncontrol@cdph.ca.gov)  
or  
fax to "HAI Program" at (510) 620-3425.**

For questions, please contact Sue Chen at [sue.chen@cdph.ca.gov](mailto:sue.chen@cdph.ca.gov) or phone (510) 620-3434.

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<sup>1</sup> Include influenza vaccines administered in settings other than the reporting hospital.

**SAMPLE**

**Attachment B1 (Contains Influenza Information)**

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**Influenza vaccine consent**

I have read the "Influenza Vaccine Information Statement, date XXXX". I have had an opportunity to ask questions which were answered to my satisfaction. I understand the benefits and risks of influenza vaccine.

**Print name** \_\_\_\_\_ **Department** \_\_\_\_\_

I request that the vaccine be given to me.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**I decline the vaccine today because I have already had a flu shot this year.**

Clinic where vaccinated \_\_\_\_\_ Date vaccinated \_\_\_\_\_ (Approximate is OK.)

Signature \_\_\_\_\_ Date signed \_\_\_\_\_ We will count you as vaccinated.

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**Influenza vaccine declination**

**Written declination is required by new California law (SB 739) beginning in 2007.**

I acknowledge that I am aware of the following facts:

- Influenza is a serious respiratory disease that kills, on average, 36,000 Americans every year.
- Influenza virus may be shed for up to 48 hours before symptoms begin, allowing transmission to others.
- Up to 30% of people with influenza have no symptoms, allowing transmission to others.
- Flu virus changes often, making annual vaccination is necessary. Immunity following vaccination is strongest for 2 to 6 months. In CA, influenza usually arrives around New Year through February or March.
- I understand that flu vaccine cannot transmit influenza. It does not, however, prevent all disease.
- 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.

**Knowing these facts, I choose to decline vaccination at this time.** I may change my mind and accept vaccination later, if vaccine is available. I have read and fully understand the information on this declination form.

**Print name** \_\_\_\_\_ **Department** \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

I decline vaccination for the following reason(s). Please check all that apply.

- I believe I will get the flu if I get the shot.
- I do not like needles.
- My philosophical or religious beliefs prohibit vaccination.
- I have a medical contraindication to receiving the vaccine.
- Other reason – please tell us. \_\_\_\_\_
- I do not wish to say why I decline.

**Attachment C (Influenza Information on Intra-hospital Website)**

**Hospital**

**Employee Occupational Health Department**

**DATE INFLUENZA CONSENT FORM (INJECTABLE VACCINE)**

I have read or have had explained to me the information on the Vaccine Information Statement [VIS] about the influenza vaccine. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the influenza vaccine and:

- Request that the vaccine is given to me, or the person named below, for whom I am authorized to make this request **OR**  
 Decline the vaccine at this time. **I acknowledge that influenza vaccination is recommended by the Centers for Disease Control (CDC) for all healthcare personnel to prevent infection from and transmission of influenza and its complication, including death, to patients, coworkers, family, and community OR**  
 I have already received the vaccination at \_\_\_\_\_ [where]

**STRAINS:**

**INFORMATION ON PERSON TO RECEIVE DATE xxxx VACCINE:** Please Print

<b>Last Name (Print):</b>	<b>First Name (Print):</b>	<b>Initial:</b>
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<b>Signature (Person to receive vaccine or person authorized to make request):</b>	<b>Today's Date: (Date VIS given):</b>
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<b>Date of Birth:</b>	<b>Age Group:</b>	<b>Facility:</b>	<b>Please Mark One:</b>
<b>Street Address:</b>	<input type="checkbox"/> 18-49	<b>Unit/Dept.:</b>	
<b>City:</b>	<input type="checkbox"/> 50-59		
<b>State:</b>	<input type="checkbox"/> 60-64	<input type="checkbox"/> Employee	
<b>Zip:</b>	<input type="checkbox"/> 65+ years	<input type="checkbox"/> Volunteer	
			<input type="checkbox"/> Physician
			<input type="checkbox"/>

**PLEASE ANSWER THE FOLLOWING:**  
 Do you have a serious allergy to eggs?  Yes  No  
 Have you ever had a serious allergic reaction or other problem after getting an influenza vaccine?  Yes  No  
 Were you ever paralyzed by Guillain-Barre syndrome?  Yes  No  
**Are you pregnant or think you may be pregnant?**  Yes\*  No \*If so, please go to EOHD for single dose vaccine without thimerosal.  
 Do you now have a moderate or severe illness?  Yes  No  
 Have you ever had a reaction or an allergy to latex?  Yes  No  
 Do you have a serious allergy to thimerosal  Yes  No

**DO NOT WRITE BELOW THIS LINE – FOR CLINICAL USE ONLY**

<b>Facility or EOHD clinical Site where given:</b>	<b>Date Vaccinated:</b>	<b>VIS Date: 06/30/2006</b>
	<b>Lot Number:</b>	<b>EXP:</b>
		<b>MFR:</b>

<b>Dose:</b> 0.5ml	<b>Route:</b> IM	<b>Nurse's Signature:</b>
<b>Right Deltoid</b> <input type="checkbox"/>	<b>Left Deltoid</b> <input type="checkbox"/>	

**Employee who can transmit influenza to persons at high risk:**  Yes  No  
 (Physicians, nurses, and other personnel in hospitals, outpatient settings, nursing homes/SNF and providers of home care to persons in high-risk groups.)

# SAMPLE

## Attachment D

### Summary of DATE xxxx Influenza Information for Hospital Employees

Please indicate your understanding of the information below. (Complete influenza information is included in the pandemic influenza safety module. Please refer to the safety module for complete information. )

Influenza is an annual respiratory illness with symptoms of fever, cough, achiness, and fatigue. Influenza is transmitted from person to person by large droplets expelled into the air or by hands/objects contaminated with the virus that touch the face (nose, mouth, eyes). It is associated with 36,000 deaths each year in the U.S and can be best prevented by annual vaccination which is available at no cost to employees on site each year through roaming carts/ buckets, employee flu clinics, and on a walk-in basis in Employee and Occupational Health Department.



Additionally, practicing hand hygiene, covering the mouth/nose when coughing/sneezing, avoiding touching facial areas, and staying home when ill can also help protect patients, family and others from influenza and other illnesses.



Example of web-based influenza education

Please click on the "Take Test" button on the left to indicate your understanding.

## Attachment E



# Pre-season Survey on Influenza Vaccination Programs for Healthcare Personnel

OMB No. 0920-0666  
Exp. Date: xx-xx-20xx

Page 1 of 2

Facility ID #: \_\_\_\_\_

Date Entered: \_\_\_\_\_

(Month/Year)

For Season: \_\_\_\_\_ - \_\_\_\_\_

(Specify years)

Which personnel groups do you plan to include in your annual influenza vaccination program?

- All personnel who work in the facility
- All personnel who work in clinical areas, including those without direct patient care duties (e.g., clerks, housekeepers)
- Only personnel with direct patient-care duties (e.g., physicians, nurses, respiratory therapists)

Which of the following types of employees do you plan to include in your annual influenza vaccination program? (check all that apply)

- Full-time employees
- Part-time employees
- Contract employee
- Volunteers
- Others, specify: \_\_\_\_\_

At what cost will you provide influenza vaccine to your healthcare workers?

- No cost
- Reduced cost
- Full cost

Will influenza vaccination be available during all work shifts (including nights and weekends)?

- Yes
- No

Which of the following methods do you plan to use this influenza season to deliver vaccine to your healthcare workers? (check all that apply)

- Mobile carts
- Centralized mass vaccination fairs
- Peer-vaccinators
- Provide vaccination in congregate areas (e.g., conferences/meetings or cafeteria)
- Provide vaccination at occupational health clinic
- Other, specify: \_\_\_\_\_

Assurance of Confidentiality: The information obtained in this surveillance system that would permit identification of any individual or institution is collected with a guarantee that it will be held in strict confidence, will be used only for the purposes stated, and will not otherwise be disclosed or released without the consent of the individual, or the institution in accordance with Sections 304, 306 and 308(d) of the Public Health Service Act (42 USC 242b, 242k, and 242m(d)).

Public reporting burden of this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC, Reports Clearance Officer, 1600 Clifton Rd., MS D-74, Atlanta, GA 30333, ATTN: PRA (0920-0666).

CDC 57.75HH (Front) Effective date xx/xx/20xx



# Pre-season Survey on Influenza Vaccination Programs for Healthcare Personnel

OMB No. 0920-0566  
Exp. Date: xx-xx-20xx

Page 2 of 2

Which of the following strategies do you plan to use to promote/enhance healthcare worker influenza vaccination at your facility? (check all that apply)

- No formal promotional activities are planned
- Incentives
- Reminders by mail, email or pager
- Coordination of vaccination with other annual programs (e.g., tuberculin skin testing)
- Require receipt of vaccination for credentialing (if no contraindications)
- Campaign including posters, flyers, buttons, fact sheets
- Other, specify:

Do you plan to conduct any formal educational programs on influenza and influenza vaccination for your healthcare workers?

- Yes
- No

If you conduct formal educational programs on influenza and influenza vaccination, will your healthcare workers be required to attend?

- Yes
- No

Will you require healthcare workers who receive off-site influenza vaccination to provide documentation of their vaccination status?

- Yes
- No

Will you require signed declination statements from healthcare workers who refuse influenza vaccination?

- Yes
- No

## Attachment F



# Post-season Survey on Influenza Vaccination Programs for Healthcare Personnel

OMB No. 0920-0666  
Exp. Date: xx-xx-20xx

Page 1 of 2

Facility ID #: \_\_\_\_\_

Date Entered: \_\_\_\_\_  
(Month/Year)

For Season: \_\_\_\_\_ - \_\_\_\_\_  
(Specify years)

Which personnel groups did you include in your annual influenza vaccination program this past season?

- All personnel who work in the facility
- All personnel who work in clinical areas, including those without direct patient care duties (e.g., clerks, housekeepers)
- Only personnel with direct patient-care duties (e.g., physicians, nurses, respiratory therapists)

Which of the following types of employees did you include in your annual influenza vaccination program this past season? (check all that apply)

- Full-time employees
- Part-time employees
- Contract employee
- Volunteers
- Others, specify: \_\_\_\_\_

At what cost did you provide influenza vaccine to your healthcare workers?

- No cost
- Reduced cost
- Full cost

Did you provide influenza vaccination during all work shifts (including nights and weekends)?

- Yes
- No

Which of the following methods did you use during influenza season to deliver vaccine to your healthcare workers? (check all that apply)

- Mobile carts
- Centralized mass vaccination fairs
- Peer-vaccinators
- Provide vaccination in congregate areas (e.g., conferences/meetings or cafeteria)
- Provide vaccination at occupational health clinic
- Other, specify: \_\_\_\_\_

**Assurance of Confidentiality:** The information obtained in this surveillance system that would permit identification of any individual or institution is collected with a guarantee that it will be held in strict confidence, will be used only for the purposes stated, and will not otherwise be disclosed or released without the consent of the individual, or the institution in accordance with Sections 304, 305 and 308(d) of the Public Health Service Act (42 USC 242b, 242k, and 242m(d)).

Public reporting burden of this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC, Reports Clearance Officer, 1600 Clifton Rd., MS D-74, Atlanta, GA 30333, ATTN: PRA (0920-0666).

CDC 57-750 (Front) Effective date xx/xx/20xx



# Post-season Survey on Influenza Vaccination Programs for Healthcare Personnel

OMB No. 0920-0666  
Exp. Date: xx-xx-20xx

Page 2 of 2

Which of the following strategies did you use to promote/enhance healthcare worker influenza vaccination at your facility? (check all that apply)

- No formal promotional activities are planned
- Incentives
- Reminders by mail, email or pager
- Coordination of vaccination with other annual programs (e.g., tuberculin skin testing)
- Require receipt of vaccination for credentialing (if no contraindications)
- Campaign including posters, flyers, buttons, fact sheets
- Other, specify:

Did you conduct any formal educational programs on influenza and influenza vaccination for your healthcare workers?

- Yes
- No

If you conduct formal educational programs on influenza and influenza vaccination, did you require your healthcare workers to attend?

- Yes
- No

Did you require healthcare workers who received off-site influenza vaccination to provide documentation of their vaccination status?

- Yes
- No

Did you require signed declination statements from healthcare workers who refused influenza vaccination?

- Yes
- No

## Attachment G



# Healthcare Personnel Safety Component Facility Survey

OMB No. 0920-0666  
Exp. Date: xx-xx-20xx

Page 1 of 2

Tracking#: _____															
Facility ID#: _____	*Survey Year: _____														
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 50%;">*Facility Information</th> <th style="width: 50%;">*Number of:</th> </tr> </thead> <tbody> <tr> <td>Acute care beds</td> <td></td> </tr> <tr> <td>Patient admissions</td> <td></td> </tr> <tr> <td>Inpatient days</td> <td></td> </tr> <tr> <td>Outpatient visits</td> <td></td> </tr> <tr> <td>Total number of part-time personnel</td> <td></td> </tr> <tr> <td>Total number of full-time personnel</td> <td></td> </tr> </tbody> </table>		*Facility Information	*Number of:	Acute care beds		Patient admissions		Inpatient days		Outpatient visits		Total number of part-time personnel		Total number of full-time personnel	
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**Attachment H (Attestation for Non-employee MDs)**

# HOSPITAL

## MEDICAL STAFF OFFICE

### Screening for Influenza Vaccination for Physicians

<b>Name:</b>	<b>Physician ID#:</b>	<b>Today's Date:</b>
<b>Address:</b>	<b>Office Phone:</b> (    )	<b>Office FAX:</b> (    )

**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 influenza.
- 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.
- I am afraid of needles
- 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:** \_\_\_\_\_