

COVID-19 VACCINATION DECLINATION/ATTESTATION 2020-2021

Name: _____

Date: _____

DOB: _____

I understand that due to the high national infection rate, the pandemic, combined with any additional personal risk factors (*work exposure, comorbidities, congregate or group living status*) I may be at increased risk of acquiring COVID-19. I have been given the opportunity to be vaccinated against COVID-19 at no charge to me. However, I decline the vaccination at this time. I understand that by declining this vaccine I continue to be at increased risk of acquiring COVID-19. If, during this COVID-19 disease cycle, I continue to have increased exposure to aerosol transmissible diseases (including COVID-19) and want to be vaccinated, I can receive the vaccination from St. Lawrence Health System.

INSTRUCTIONS: complete Option 1 OR Option 2 citing reason.

- Option 1- Declination

By reviewing **and initialing** the three boxes below, you are submitting your declination to receive COVID-19 vaccine at this time.

_____ I understand the information regarding COVID-19 vaccine and the potential value for healthcare workers;

_____ I am choosing to decline the vaccine at this time; and

_____ I understand that I can choose to receive the vaccine at a later time when it is available.

- Option 2- Attestation:

I have received the COVID-19 vaccine elsewhere. Please indicate where and provide proof of vaccination with this form Primary Physician Worksite

Other _____

OPTIONS for submitting (insert facility specific contact/submission information here)

I acknowledge and confirm that the above information is correct.

Signature: _____

Date: _____

Please send to the Occupational Health Office via fax 315-261-5024 or via email employeehealth@cphospital.org.
Please direct questions to 585.454.8202.