



EMPLOYEE DECLINATION FORM

Name: _____ Date: ____/____/____

Dept.: _____ Dept.#: _____

I understand that due to my occupation, exposure to blood, other bodily fluids, or potentially infectious materials, may put me at risk for infectious diseases. I understand that I have been given the opportunity to be vaccinated for the following diseases at no charge to myself.

However, at the present time, I am declining the following vaccination(s) and/or test(s) shown below. I understand that by declining the following vaccination(s), I am at risk of acquiring the disease. I understand that I can receive the following vaccination(s) or test(s) at any time.

Vaccination/ Test:	Reason:

Employee Signature: _____ Date: ____/____/____

Supervisor/Department Head: _____

*Submit Form to the Office of Risk & Safety.
A copy of this will be placed in your Personnel file.*