

Seasonal Influenza Vaccination 2018-2019 Reporting Form

The Joint Commission, Center for Medicare and Medicaid Services, and the Massachusetts Department of Public Health requires that every employee who is on site at the hospital for one day or more between the period of October 1st and March 31st of the year be vaccinated against the flu or sign a statement indicating that he/she does not want to be vaccinated.

In order to meet this requirement you must complete the following and return it to Employee Health Services.

Please check one of the boxes below to indicate whether you have been vaccinated against flu or choose not to be vaccinated.

I received the Flu shot for this fall/winter flu season: You must check where you have received the vaccine from one of the choices below:

- _____ I received my flu shot at Employee Health Services or from one of my Peers.
- _____ I received my flu shot at a Partners provider other than Employee Health.
- _____ I received my flu shot at a provider not associated with Partners.

I do not wish to receive the flu shot. I have the opportunity to be vaccinated against the flu at no charge to myself. I understand that I may change my mind at any time and get vaccinated against the flu, if vaccine is available. You must also check why you are declining to be vaccinated from one of the choices below:

- _____ I have a medical contraindication to vaccination or am allergic to a vaccine component.
- _____ I believe the flu shot can cause the flu or flu like illness
- _____ I believe the flu shot is not necessary as I never get the flu
- _____ I have a fear of needles
- _____ I cannot be vaccinated due to a religious reason.
- _____ Other

(Please specify): _____

Print Name _____

Date of Birth: _____

Position: _____

Department: _____

Signature _____

Today's Date _____

TO BE RETURNED TO EMPLOYEE HEALTH SERVICES
Fax: 413.582.2961