Department of Veterans Affairs

SEASONAL INFLUENZA VACCINATION PROGRAM FOR VHA HEALTH CARE PERSONNEL FORM

PRIVACY ACT STATEMENT: This information is collected under the authority of the Privacy Act of 1974 and 5 U.S.C. § 552a, which authorize Federal agencies to collect, maintain, and disclose personal information and Executive Order 9397 (as amended by E.O. 13478) to protect identifiers against unlawful use. This information is necessary for identity verification, personnel actions, and records management to support required workplace health and safety protocols. VA may disclose the information on the form as permitted by law. Routine uses of this information may be identified in the VA system of records 08VA05, Employee Medical File System Records (Title 38)-VA, and the Office of Personnel Management (OPM) system of records OPM/GOVT-10, Employee Medical File System Records, published in the Federal Register in accordance with the Privacy Act of 1974. Completion of this form is voluntary; however, failure to complete the form or incomplete, misleading, or untruthful information provided on the form may result in delays in processing the form, termination of employment, or criminal sanction. The form collects protected health information and personal identifying information. VA will use it to obtain information relevant to determining eligibility for employment and other purposes authorized or required by law.

INSTRUCTIONS: Select one option below, then complete and sign the last section of this form.

OPTION 1

☐ I **RECEIVED the seasonal influenza vaccine this flu season** *(Please indicate location of vaccination below)*:

- ☐ **Within** the EOH Program *(Documented proof of vaccination is not required)*.
- ☐ **Outside** the EOH Program with either a personal health care or VHA primary care provider *(Documented proof of vaccination must be submitted with VA Form 10-9050)*.

OPTION 2

☐ I am requesting a **MEDICAL EXCEPTION** to the VHA Seasonal Influenza Vaccination Program for VHA HCP.
I have a contraindication for influenza vaccine as defined by the Centers for Disease Control and Prevention (CDC). The reasons for contraindication must be recognized contraindications and precautions by the CDC, found here: https://www.cdc.gov/flu/vaccines/vaccinations.html. This has been discussed and acknowledged by my personal physician, and I have notified my immediate supervisor.

PHYSICAN LAST NAME, FIRST NAME *(print)*:

PHYSICIAN SIGNATURE:	DATE *(MM/DD/YYYY)*:	NPI NUMBER:
SUPERVISOR SIGNATURE:	DATE *(MM/DD/YYYY)*:	SUPERVISOR VA.GOV EMAIL:

OPTION 3

☐ I am requesting a **RELIGIOUS EXCEPTION** to the VHA Seasonal Influenza Vaccination Program for VHA HCP. I notified my immediate supervisor in writing that I have a deeply held religious belief that prevents me from receiving the seasonal influenza vaccine this influenza season.

SUPERVISOR SIGNATURE:	DATE *(MM/DD/YYYY)*:	SUPERVISOR VA.GOV EMAIL:

COMPLETE AND SIGN

☐ I have read and fully understand the information on this form and have been given the opportunity to have my questions answered. I understand that violation of VHA policy may result in disciplinary action up to and including removal from Federal service. I understand that completing this form supports compliance with the VHA Seasonal Influenza Vaccination Program for VHA HCP. I understand that if I do not receive the vaccine by November 30, or within two weeks of beginning employment, I must wear a face mask in accordance with VHA policy.

EMPLOYEE/PERSON TYPE:
☐ VHA EMPLOYEE ☐ WOC APPOINTEE/VOLUNTEER ☐ OTHER *(explain)*: _____

EMPLOYEE LAST NAME, FIRST NAME *(print)*:	DATE OF BIRTH *(MM/DD/YYYY)*:
EMPLOYEE SIGNATURE:	DATE *(MM/DD/YYYY)*: