

COVID-19 Vaccination Declination Form 2023

Employee NAME (PLEASE PRINT): _____

JOB TITLE: _____

My employer, **Chosen Family Home Care**, requires I receive a COVID-19 vaccination to protect the participants/clients I serve. I acknowledge I am aware of the following facts:

- COVID-19 is a serious disease that kills thousands of people in the United States.
- COVID-19 vaccination is recommended for me and all other healthcare workers to protect the participants/clients from COVID-19 its complications, and death.
- If I contract COVID-19 I can shed the virus before symptoms appear. My shedding the virus can spread COVID-19 to participants/clients.
- If I become infected with COVID-19, I can spread severe illness to others even when my symptoms are mild or non-existent.
- I understand I cannot get COVID-19 from the vaccine.
- The consequences of refusing to be vaccinated could have life-threatening consequences to my health and the health of all those with whom I have contact.

Despite these facts, I am choosing to decline COVID-19 vaccination right now for the following reason(s):

- ☐ Medical reason
- ☐ Religious exemption
- ☐ Other _____

I understand I can change my mind at any time and receive a COVID-19 vaccination. I have read and fully understand the information on this declination form.

I understand because I have declined the COVID-19 vaccination, I am required to continue wearing a mask that has been provided to me at all times during each scheduled shift. In addition, I understand I must contact my Human Resources Business Partner to discuss the reason(s) for my declination. If I fail to comply with the requirements of wearing a mask and contacting HR, I understand that I may be subject to disciplinary actions up to and including termination of employment.

Management reserves the right to skip steps in the corrective action process, should it be warranted.

Employee Signature for Declination: _____

Date: _____