**Exemption of Seasonal Influenza Vaccination for Medical Contraindication 2022-2023**

**NOAH** has required that I receive seasonal influenza vaccination in order to protect myself, my co-workers, and the patients I serve. Only evidence-based medical contraindication against seasonal influenza vaccination confirmed by a Licensed Health Care Provider (MD, DO, PA or NP) will be accepted as an exception to the required **Influenza Vaccine Requirements for Healthcare Personnel Policy.** Medical contraindication must be re-assessed each year and an updated exemption form must be completed and **submitted annually**.

This **Medical Exemption Form** must be completed by the Employee’s Care Provider (MD, DO, PA or NP) and returned to Employee Health.

Return forms to: [NOAHHR@honorhealth.com](mailto:NOAHHR@honorhealth.com)

I decline the seasonal influenza vaccination due to a medical contraindication. I understand that because I work in a health care environment, I may place patients and co-workers at risk if I work while infected with the influenza virus.

I understand that I will be required to wear a mask at all times (except while eating or drinking) upon entry to any NOAH facility during any scheduled shifts in which patients may be present, including Dreamy Draw Admin Building, for the duration of the influenza season **(September 6 – May 1st)**.

I understand that masking is required to support the infection prevention policies and practices at NOAH.

**Please Check One:**

Employee **-**  \_\_\_\_\_\_\_\_\_\_\_ Dept. Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#\_\_\_\_\_**-**\_\_\_\_\_\_**-**\_\_\_\_\_\_\_

DOB\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ Supervisors Name Printed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Clinic (Please Check One):**

Desert Mission ChollaMidtownVenado CopperwoodPalominoDreamy Draw Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SIGN First and Last Name** **PRINT First Name** **MI**  **PRINT Last Name**

***THIS SECTION SHOULD BE COMPLETED BY THE EMPLOYEE’S CARE PROVIDER (MD, DO, PA or NP)***

I have evaluated \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and attest this employee has one or more of the

(Patient’s Name Here)

medical contraindications to **inactivated** influenza vaccination.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_**-**\_\_\_\_\_\_\_**-**\_\_\_\_\_\_\_\_\_ \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_

Care Provider (MD, DO, PA or NP) Print Name Phone Number Date

**Employee Health Use Only**

**Approved  Not Approved**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_\_**

**Signature Date**