MON HEALTH SYSTEM
2019-2020 HEALTHCARE PERSONNEL INFLUENZA VACCINATION ATTESTATION
To be completed by employees, licensed independent practitioners, students, trainees, volunteers aged 18 or older, and contract personnel

Beginning with the 2013-2014 influenza season, acute care facilities must report summary data on influenza vaccination of healthcare personnel (HCP) who physically work in the reporting facility for **1 day or more** from **October 1, 2019 - March 31, 2020.** Hospitals must report vaccinations received by healthcare personnel at the facility, vaccinations received outside the facility, medical contraindications, and declinations.

Due to the June 2016 recommendation from the CDC's Advisory Committee on Immunization Practices, Mon Health System will **NOT** accept documentation of Flumist® vaccination as evidence of influenza vaccination.

For more information, please refer to http://www.cdc.gov/flu/about/qa/nasalspray.htm

When form complete sign and date at bottom of page.

Please select the HCP description that best describes you:
☐ **Employee** (receive a paycheck directly from MHS)
☑ **Student/Trainee** (includes intern, medical resident, job shadowing) ☐ **Volunteer** (18 or older)
☐ **Licensed independent practitioner** (non-employee)
☐MD/DO ☐PA ☐NP ☐CRNA ☐Midwife ☐Other _____
☐ **Contract Personnel** (work at MHS through a contract and do not fall into category above)

	Yes	No
Did you receive an influenza vaccination **at MHS** this season? If yes, **STOP** - no further answers required		
Did you receive an influenza vaccination **outside of MHS** this season? If yes, please document the facility where it was provided and the date it was given. **Documentation required.**		
Facility:	Date:	

Name (print full name): _____ Date: _____

Signature: _____

I am unable to consent to flu vaccination at this time due to the medical exclusion listed below. I am aware I may change my mind and accept vaccination later, if vaccine is available.

I **decline** vaccination for the following reason:

Medical Exclusion (Physician excuse required)

- ○ I have an anaphylactic reaction to eggs
- ○ I have had Guillain-Barré syndrome

Name (print full name): _____ Date: _____

Signature: _____