DEPARTMENT OF HEALTH SERVICES **STATE OF WISCONSIN**
Division of Enterprise Services
F-02718 (09/2021)

EMPLOYEE OPT-OUT NOTIFICATION OF INFLUENZA VACCINATION

IMPORTANT SUBMITTAL INFORMATION

This form **must** be approved by the proper Appointing Authority (or designee) and submitted to your local HR staff at your facility **or** for all other staff via email to DHSHumanResources@dhs.wisconsin.gov no later than the beginning of the official influenza season.

ACKNOWLEDGEMENT OF MEDICAL FACTS & RISKS WITH SEASONAL INFLUENZA AND VACCINES

In accordance with **Human Resources Policy and Procedure 604 – Influenza Vaccinations**, the Department of Health Services (DHS) has informed me that I am required to receive the seasonal influenza vaccination as a condition of employment for the protection of those under DHS' care or charge, employees and, others associated with DHS operations. I acknowledge that I am aware of the following medical facts and risks associated, as provided by the CDC, with seasonal influenza and related vaccinations:

1.	Seasonal influenza is a serious respiratory disease that has resulted in between 140,000 – 810,000 hospitalizations and between 12,000 – 61,000 deaths in the U.S. annually since 2010. Source: U.S. Centers for Disease Control
2.	If I become infected with influenza, even when my symptoms are mild or non-existent, I may spread the illness to others.
3.	I understand the strains of the viruses associated with seasonal influenza infection change from year-to-year which is why a different influenza vaccine is recommended each year.
4.	I have been informed that I cannot get infected with the virus from receiving the influenza vaccine.
5.	My refusal to be vaccinated could have life-threatening consequences to my health and the health to those which I have close contact, including those for which I provide care, co-workers and their family members, my family, and the community at large.

I AM DECLINING TO RECEIVE THE SEASONAL INFLUENZA VACCINE FOR THE FOLLOWING REASONS: (Check all that apply)

- ☐ I do not support the use of vaccines for religious reasons;
- ☐ I am concerned about the potential side effects and/or safety of the vaccine;
- ☐ I do not believe the vaccine is effective at reducing the risk of seasonal influenza;
- ☐ I have a medical concerns related to receiving the vaccine.
- ☐ Other Reason (Please share with us the concerns you have):

EMPLOYEE ACKNOWLEDGEMENT IF SEASONAL INFLUENZA DECLINED

My signature below confirms that I have read HRPP 604 and understand that I may opt out of the requirement for a seasonal influenza vaccination. I further acknowledge that I must wear a surgical mask during the entire influenza season as required by HRPP 604 and that failure to comply with the requirements of HRPP 604 **may result in me being required to use paid time off and/or being subject to the progressive discipline process, including potential termination.** Lastly, I acknowledge that I may change my mind at any time and submit proof of vaccination in lieu of being required to comply with the surgical mask requirement.

* Required fields

Last Name *	First Name *	M.I. *	Employee ID Number *

SIGNATURE – Employee*	Date Signed

APPOINTING AUTHORITY ACKNOWLEDGMENT

Last Name *	First Name *	M.I. *	☐ I confirm that I am aware of this employee's choice to opt for wearing a surgical mask in lieu of receiving an influenza vaccine per HRPP 604.