ATTACHMENT A

PRINT EMPLOYEE NAME: ______________________________ **TITLE:** ________________

INFLUENZA VACCINATION FORM

○ I have already received the Influenza Vaccine and submitted documentation to support this.

Date immunized: ____

Individual who administered Influenza Vaccine:

Name: ______________________________ Title: ________________

Address: ____

Telephone: ____

○ I have not receive the Influenza Vaccine.

☐ I am declining the Influenza Vaccine for the following reasons: ☐ Medical ☐ Religious ☐ Personal

I have been informed that it is mandatory for me to wear a surgical mask and I agree to wear a mask upon entering patient's home for the duration of my visit in order to prevent contraction and/or transmission of infectious air borne materials.

☐ For medical reasons, must have NYC DOH 4482 form filled out by physician, physician assistant, nurse practitioner, nurse-midwife, or licensed midwife.

☐ I understand that by declining the influenza vaccine I continue to be at risk of acquiring influenza virus, if, in the future while employed by Crown of Life Care NY LLC I decide to be vaccinated for the influenza virus I am free to consult with my PCP and receive the vaccine.

☐ I have been informed where I can obtain Influenza Vaccine.

☐ I further understand that the agency will provide me with a surgical mask at no cost to me.

☐ I have received several masks from the agency and when needed will request additional masks.

☐ I acknowledge a red dot has been placed on my photo identification.

EMPLOYEE SUGNATURE: ______________________________ **DATE:** ________________

WITNESS SIGNATURE: ______________________________ **DATE:** ________________