VACCINATION ACKNOWLEDGMENT AND EXEMPTION REQUEST

It is the policy of St. David's Healthcare that employees, volunteers, and students demonstrate immunity to the following vaccine preventable diseases: **Mumps, Rubella, Rubeola, Varicella, Tetanus, Diphtheria, Pertussis, and seasonal Influenza.**

Reasonable Accommodation—the reasonable accommodation that St. David's Healthcare is making for individuals requesting an exemption to this policy is the use of protective equipment (surgical masks) and other infection prevention measures as indicted when in a patient care area or within 6 feet of a patient.

I acknowledge that I have read and understand the following:

- The consequences of my not being vaccinated could have life-threatening effects on my health and the health of those with whom I have contact with, including patients, my co-workers, my family, and my community.
- I understand that the reasonable accommodation for not being vaccinated is to wear personal protective equipment (surgical mask) in required areas.
- I understand that St. David's Healthcare makes available medical professionals to discuss any concerns I have regarding vaccine safety and effectiveness.

I am requesting an exemption to St. David's Healthcare's vaccine-preventable disease policy with respect to the following Vaccinations: (Please Circle)

Varicella (Chicken Pox) MMR (Rubella, Rubeola, Mumps) Tdap (Tetanus, Diphtheria, Pertussis) Seasonal Flu

I request an exemption based on the following:

☐ Centers for Disease Control and Prevention Recognized Medical Contraindication or Precaution to vaccination

Indicate reason: _____

Select Medical Condition: Temporary Medical Condition Permanent Medical Condition

☐ Religious Belief

☐ Conscientious Objection **Indicate Reason:** _____

☐ I will not be working directly with patients or in a patient care area

I understand that in order to maintain a safe work environment for patients and staff that I will be required to wear personal protective equipment, may be reassigned or furloughed following an unprotected exposure, and may need to conform to other alternative infection control measures while at work. I understand that being required to wear personal protective equipment is not considered retaliatory or discriminatory under state law.

I understand that St. David's Healthcare is allowed under state law to take disciplinary actions against me if I fail to comply with these requirements. I understand that in the event of a public health disaster, St. David's Healthcare is allowed to prohibit me from having contact with patients.

I consent to the release of this request and including any supporting documentation to all such representatives of St. David's Healthcare on a need-to-know basis.

Signature _____ Date _____

Name (print) _____ 3 – 4 ID or Date of Birth: _____

Department _____ Facility _____