TITLE/DESCRIPTION: Influenza Vaccination
DEPARTMENT: Infection Prevention and Control/Employee Health
PERSONNEL: All
EFFECTIVE DATE: 8/13
REVISED DATE:

## I. PURPOSE

The purpose of this policy is to help protect patients, employees, employees' family members, and others affiliated with Springhill Medical Center from acquiring seasonal influenza disease and to help prevent the unnecessary spread of the influenza virus. The most effective way to prevent infection from influenza virus is through annual influenza vaccination.

## II. POLICY

As a condition of practice and/or employment, SMC requires all healthcare personnel to have annual influenza vaccination or present an approved medical or religious exception.

## III. PROCEDURE

### A. Employee Information and Responsibilities

It is the responsibility of all employees and any employee in a supervisory position to understand this policy and to follow associated principles or guidelines, as applicable. Each Department Manager will ensure that the following and any affiliate-specific guidelines or standards are uniformly applied through appropriate education and corrective action as necessary.

Individual employee questions or inquiries regarding this policy or any associated procedures should be directed to the employee's supervisor or the Director of Infection Prevention and Control. Any supervisory or management questions or inquiries which cannot be answered by their Manager, Director, or Vice President (as appropriate) should be directed to the Director of Infection Prevention and Control.

### B. Definitions

Healthcare personnel are defined as individuals including but not limited to: all employees, employed licensed independent practitioners (MD, DO, PA & advanced practice clinicians), volunteers, students, and personnel.

# Medical Exemption Request From Influenza Vaccination

Please print information below:

Name: ______________________________ Employee #: ______________________

Phone #: ____________________________ Department Name: ___________________

Physician Name: _____________________ Physician Phone #: ___________________

**This medical declination form must be completed by your primary care physician and then returned to Employee Health.**

I understand since I have an evidence-based medical contraindication to influenza vaccination that I will be required to wear a mask when within 6 feet of a patient during a scheduled shift through the duration of the influenza season.

Signature of employee: ______________________________ Date: __________________

## This section must be completed by primary care physician

I have evaluated this employee and can verify that he/she has one or more of the following medical contraindications to the influenza vaccine:

- ☐ Documented severe allergy to eggs or egg products
- ☐ Severe allergic reaction to previous influenza vaccine
- ☐ History of Guillain-Barre' Syndrome within six weeks of receiving a previous influenza vaccine
- ☐ Other: (please explain – only evidence-based medical contraindications): _______________

_____________________________________________________________________________

Physician Signature:_______________________________ Date:_____________________

Signature Stamp NOT Acceptable

# Religious Exemption Request From Influenza Vaccination

Springhill Medical Center (SMC) is committed to diversity and inclusiveness of all our employees. We highly recommend that all healthcare personnel, clinical and non-clinical, be vaccinated against influenza yearly during the flu season. If you have declined to receive the flu vaccine for religious reasons, please provide the following information:

Name: ______________________________ Employee #: ________________________

Phone #: ____________________________ Department Name: ____________________

"Because the Influenza Vaccination Policy conflicts with my sincerely held religious beliefs and practices or membership in a church or religious body, I decline the Influenza vaccination at this time."

Name of Religious Belief, Church or Religious Body: __________________________________

**Religion Tenet(s) Documentation**

*In some cases, SMC may need to obtain documentation or other authority regarding your religious practice or belief. We may need to discuss the nature of your religious belief(s), practices and accommodation with your religion's spiritual leader (if applicable) or religious scholars to address your request for an exemption.*

If requested, can you obtain documentation or other authority to support the need for an exemption based on your religious practice or belief? Yes _____ No _____

If no, explain why: ______________________________________________________________

______________________________________________________________________________

**Verification and Accuracy**

I verify that the above information is complete and accurate to the best of my knowledge and I understand that any intentional misrepresentation contained in this request may result in disciplinary action.

I also understand that my request for an exemption may not be granted if it is not reasonable or if it creates an undue hardship on my employer. However if my request is granted I understand I will be required to wear a mask when within 6 feet of a patient during a scheduled shift through the duration of the influenza season.

Signature: _________________________________ Date: _________________________

This request will be reviewed and acknowledged by Infection Prevention and Control/ Employee Health. You will be notified of the decision regarding your requested exemption.