**Declination of COVID-19 Vaccination For Healthcare Personnel**Employee’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Employee’s ID#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have been advised that I am eligible to receive the COVID-19 vaccine to protect myself and the patients I serve. I have read the FDA’s [Fact Sheet](https://www.health.nd.gov/covid-vaccine-fact-sheets) and North Dakota Department of Health’s [COVID-19 Vaccine Frequently Asked Questions Handout](https://www.health.nd.gov/sites/www/files/documents/COVID%20Vaccine%20Page/COVID-19_Vaccine_FAQ_General_Public.pdf) explaining the vaccine and the disease it prevents. I have had the opportunity to discuss the fact sheets and have my questions answered by a healthcare provider.

I am aware of the following facts (please read and check each box):

* COVID-19 is a serious disease that has killed over 778,000 American since the beginning of the pandemic and was the third leading cause of death in the U.S. in 2020.
* COVID-19 vaccination is available for me and all other healthcare personnel to protect this facility’s patients from COVID-19, its complications, and death.
* If I contract COVID-19, I can shed the virus for 24-72 hours before COVID-19 symptoms appear. Further, my shedding of the virus can spread COVID-19 to staff and patients in this facility.
* If I become infected with the virus that causes COVID-19, I can spread severe illness to others even when my symptoms are mild or non-existent.
* I understand clinical trials of COVID-19 vaccines must first show they are *safe* and *effective* before any vaccine can be authorized or approved for use. The known and potential benefits of a COVID-19 vaccine must outweigh the known and potential risks of the vaccine for use under what is known as an Emergency Use Authorization (EUA).
* I understand that I cannot get COVID-19 from the COVID-19 vaccine.
* The consequences of my refusing to be vaccinated could have life-threatening consequences to my health and the health of those with whom I have contact, including all patients in this healthcare facility, coworkers, my family and my community.
* I understand that vaccinating against COVID-19 is an important tool to ending the pandemic.

I acknowledge that I have read this document in its entirety and fully understand it. Despite these facts, I have decided to decline the COVID-19 vaccine by my signature below. I realize that I may re-address this issue at any time and accept vaccination in the future.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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