MACON & JOAN BROCK
VIRGINIA HEALTH SCIENCES
AT OLD DOMINION UNIVERSITY

INFLUENZA VACCINATION
EXEMPTION REQUEST FORM

NAME:_____ DATE OF BIRTH_____/_____/_____

JOB TITLE:_____

DEPARTMENT:_____ MANAGER: _____

I request an exemption to the influenza vaccination requirement based on the following:

_____MEDICAL CONTRAINDICATION TO THE INFLUENZA VACCINE

_____RELIGIOUS OBLIGATION/RESTRICTION

I have attached the required supporting documentation as outlined in the Influenza Vaccine Policy to this request. I understand that my failure to submit acceptable medical documentation or information demonstrating my religious basis for an exemption before the end of the Designated Vaccination Period may result in my request for an exemption being denied. Note that Occupational Health uses for its criteria for medical exemption only the contraindications listed in the FDA approved package inserts for the appropriate vaccines.

I am requesting an exemption in good faith, and the information I am providing or causing others to provide on my behalf is true and correct. I understand that providing false or misleading information may be grounds for discipline up to and including discharge.

I understand and consent to the following:

- My medical exemption request will be reviewed by Occupational Health.
- My religious exemption request will be reviewed by Human Resources or Associate Dean.
- My Department Chair or Associate Dean may be consulted as part of the exemption review process.
- My Department Chair or Associate Dean will be notified if I am granted an exemption.
- My exemption may not be granted if it would pose a direct threat to others (i.e., patients, co-workers, or visitors) or if it would otherwise create an undue hardship on Macon & Joan Brock Virginia Health Sciences at Old Dominion University.

Signature:_____ Date:_____

RETURN COMPLETED FORM(S) AND DOCUMENTATION TO: Occupational Health, 735 Fairfax Avenue (Suite #926), Norfolk, VA 23507

OR FAX TO: (757) 446-7188 **OR EMAIL TO:** VHS-OccHealth@odu.edu

DESIGNATED OFFICE USE ONLY:

Medical Documentation Received (Date): ___/___/___ Religious Documentation Received (Date): ___/___/___

Approving Staff Signature:_____ Date: ___/___/___

Denial Staff Signature:_____ Date: ___/___/____

Manager Notified (Date): ___/___/___