- ☐ **Marian Regional Medical Center**
- ☐ **French Hospital Medical Center**
- ☐ **Arroyo Grande Community Hospital**
- ☐ **Pacific Central Coast Health Centers**

Print name clearly ________________________________ Department__________________________

DOB: _________________________

Dignity Health Associates:

- ❑ **Physician/ARNP/PA**
- ❑ **Contract staff**
- ❑ **Traveler**
- ❑ **Students**
- ❑ **Other_________________**

COVID-19 vaccine declination – Written declination is required.

I understand that I may be at risk of acquiring COVID-19 due to my occupational exposure to aerosol-transmissible diseases. However, I decline this vaccination at this time. I understand that I continue to be at increased risk of acquiring COVID-19 by declining this vaccine. If, during the season for which it is recommended for the administration of the COVID-19 vaccine 2023-2024, I may have occupational exposure to aerosol-transmissible diseases and want to be vaccinated. I may change my mind.

I decline vaccination for the following reasons (s). Please check all that apply.

- ❑ I have a medical contraindication to receiving the vaccine. Please state: _________________________
  Or true allergy to a component of the vaccine. Please state: ____________________________________
- ❑ Other. Please state:____

Signature ____ Date __________________________