ACCEPTANCE/DECLINATION OF RECOMMENDED LICENSED VACCINES

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<tr>
<th>Employee Name (Print):</th>
<th>UFID #:</th>
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<td>Department:</td>
<td>Project Registration #:</td>
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Instructions:
1. This form should be used to document acceptance/declination of any of the following recommended licensed vaccines*:
   TDaP (tetanus, diphtheria, pertussis), HPV (Human papillomavirus), Influenza**, Pneumococcal, and Varicella (chickenpox).
2. Review the associated disease and vaccine information sheets and complete this form.
3. Submit completed, signed Form to the Biological Safety Office (Fax: 352-392-3647).
4. For questions and assistance in completing this form, contact the Biosafety Office (352-392-1591).

*NOTE: DO NOT USE THIS FORM FOR THE HEPATITIS B VACCINE. To accept/decline the Hepatitis B vaccine please complete and submit the "UF Bloodborne Pathogen Program Training and Vaccination Form Acceptance/Declination Statement."

**NOTE: The seasonal influenza virus vaccine is REQUIRED for work with Risk Group 3 (RG3) Influenza viruses. For acceptance/declination of the influenza vaccine for work with RG3 influenza viruses please use the “Acceptance/Declination (and request to waive) Required Licensed Vaccines” Form.

A. Acknowledgement of Receipt of Information and Understanding of Risk (REQUIRED)

I UNDERSTAND that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring ___________________ infection. I understand that there is a licensed vaccine available to protect against ______________. I have read the disease and vaccine information provided to and I have been given the opportunity to be vaccinated with the ___________________________ vaccine at no charge to me.

B. Complete the appropriate section below to accept or decline the vaccine: CHOOSE ONE (REQUIRED)

☐ I ACCEPT participation in the vaccine program and have not yet received the ____________________ vaccine.
Complete the following section and take a copy of this form to the Student Health Care Center to receive the vaccine. Your supervisor or PI’s signature is REQUIRED to receive the vaccine.

______________________________  ________________________________
Position Title (Official UF)     Position #

______________________________  ________________________________
Campus Mailing Address     Phone

______________________________  ________________________________  _____________________
Supervisor/PI Name (print)              Supervisor/PI Signature     Date

☐ I RECEIVED the _____________________ vaccine on _____________________________________.
   Date(s) (month/year required).

☐ I DECLINE the ________________________ vaccine at this time. I understand that by declining the vaccine, I continue to be at risk of acquiring ______________________, a serious disease that can result in death. If, in the future, I continue to have occupational exposure to ______________________ while working at UF and I want to be vaccinated, I can receive the vaccine at no charge to me.

C. Requestor Signature (REQUIRED)

Signature: _____________________________________________  Date: ____________________________

Accept/Decline Recommended Vaccines Form  REV 02/2014