UF Environmental Health and Safety
UNIVERSITY of FLORIDA

ACCEPTANCE/DECLINATION OF RECOMMENDED LICENSED VACCINES

Employee Name (Print):	UFID #:
Department:	Project Registration #:

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: _____