UF Environmental Health and Safety
UNIVERSITY of FLORIDA

ACCEPTANCE/DECLINATION/REQUEST TO WAIVE REQUIRED LICENSED VACCINES

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

Instructions:

1. This form should be used to document acceptance/declination/request to waive the following required licensed vaccines: Anthrax, Hepatitis A, Japanese encephalitis, meningococcal, polio, rabies, vaccinia (smallpox), Typhoid, Yellow Fever, Influenza (for RG3 influenza viruses).
2. Complete Section A of this form and review associated disease and vaccine information sheets. For assistance completing this form, contact the Biosafety Office at 352-392-1591.
3. If accepting participation in the program, take the form to the SHCC to receive the vaccine.
4. Submit completed, signed form to the Biological Safety Office (Fax: 352-392-3647).
   a. If you have received the vaccine previously, an official signature from the providing physician (or authorized signature) must be provided in section 2. Alternatively, you can provide lab evidence of immunity which must accompany this form.
   b. If you are requesting a waiver, your request will be evaluated by a group consisting of the UF Occupational Medicine Provider, UF Attorney's Office, the IBC and the Biosafety Office. **A minimum of 3 of the 4 groups must vote in your favor for a waiver to be granted.**

A. To Be Completed by the Requestor:

1. 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 for which there is a licensed vaccine. I have read the vaccine factsheet provided on the Biosafety website and understand the benefits and risks of vaccination.

Signature: _____ Date: _____
Requestor

2. Complete the appropriate section to accept or decline/request a waiver: (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 # Phone

_____ _____ _____
Supervisor/PI Name (print) Supervisor/PI Signature Date

☐ **I RECEIVED** the _____ vaccine on _____.
Date(s) (month/year required)

_____ _____
Physician or Authorized Signature Date

☐ **I DECLINE** the _____ vaccine and am **requesting a waiver** for the vaccine requirement. 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 blood or other potentially infectious materials while working at UF and I want to be vaccinated with the _____ vaccine, I can receive the vaccination at no charge to me.

Please provide a brief justification for your request to waive the vaccine requirement **(REQUIRED)**:

_____

_____

3. Requestor Signature (REQUIRED)

Signature: _____ Date: _____

B. To be Completed by the Waiver Review Committee (REQUIRED if you are declining/requesting to waive vaccine requirement)

After review and discussion of the Waiver Request, the committee has voted to ☐ approve ☐ not approve the waiver request.

Signature: _____ Date: _____ Signature: _____ Date: _____
UF Occupational Health Provider UF Attorney's Office

Signature: _____ Date: _____ Signature: _____ Date: _____
UF Institutional Biosafety Committee UF Biosafety Office