[](http://onecareinc.com/index.php)

**COVID-19 Essential Worker VACCINATION DECLINATION/VERIFICATION**

2021-2022

Name: Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| Administering Entity: | Name of Entity: |  |
| □ Hospital | □ Educational Institution | □ Congregate Living |
| □ Skilled Nursing Facility | □ County Department of Public Health | □ State Department of Public Health |
| □ Pharmacy | □ Primary Care/Outpatient Clinic | □ Employee/Occupational Health Services |

I understand that due to the pandemic, combined with any additional personal risk factors *(work exposure, comorbidities, congregate or group living status, etc.)* I may be at increased risk of acquiring COVID-19 with the potential for severe and fatal consequences. I understand that if I acquire COVID-19 I will place my colleagues, family, and clients at increased risk for COVID-19 including the potential for severe and fatal consequences.

I have received vaccine education materials and I have been given the opportunity to be vaccinated against COVID-19 at no charge to me. However, I decline the vaccination at this time. I understand that by declining this vaccine I continue to be at increased risk of acquiring COVID-19. If, during the pandemic, I agree to receive vaccination, I will provide a copy of proof to One Care, Inc, where it will be kept on file.

**INSTRUCTIONS**: complete Option 1 OR Option 2 citing reason.

* Option 1- Reason(s) for declination:

□ I was diagnosed with COVID and believe that I am immune.  
□ Other: Please specify:   
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Option 2-Proof of Vaccination:

□ I have received the COVID-19 vaccine elsewhere.

Please indicate where and *provide proof of vaccination* with this form:

□ Primary Physician   
□ Worksite   
□ Pharmacy   
□ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OPTIONS for submitting** (insert facility specific contact/submission information here)

**I acknowledge and confirm that the above information is correct.**

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Received /staff initials: \_\_\_\_\_\_\_/

**(RESOURCES TO OBTAIN COVID-19 TEST AND VACCINE)**

**COVID-19 AT HOME TEST KIT-**

Pixel by LabCorp

<https://www.pixel.labcorp.com/>

**VACCINE PRE-REGISTRATION FOR PHILADELPHIA HOMECARE ESSIENTIAL WORKERS**

**GROUP 1A**

<https://www.phillyfightingcovid.com/>

**VACCINATION SITES TO BE DETERMINED**

**YOU WILL BE NOTIFIED ONCE SITES ARE COMMITTED & CONFIRMED**