S&A UNIFIED HOME CARE, INC.
2729 Coney Island Ave, Brooklyn NY 11235
Phone: (718) 980-6100 Fax: (718) 873-9311

DECLINATION OF INFLUENZA VACCINATION

Employee Full Name:_____ DOB: _____

I have been advised that I should receive the influenza vaccine to protect myself and the patients I serve. I have read the Centers for Disease Control and Prevention's (CDC) Vaccine Information Statement explaining the vaccine and the disease it prevents. I have had the opportunity to discuss the statement and have my questions answered by a healthcare provider. I am aware of the following facts:

- Influenza is a serious respiratory disease that kills thousands in the United States each year.
- Influenza vaccination is recommended for me and all other healthcare personnel to protect this facility's patients from influenza, its complications, and death.
- If I contract influenza, I can shed the virus for 24 hours before influenza symptoms appear. My shedding the virus can spread influenza to patients in this facility.
- If I become infected with influenza, I can spread severe illness to others even when my symptoms are mild or non-existent.
- I understand that the strains of virus that cause influenza infection change almost every year and, even if they don't, my immunity declines over time. This is why vaccination against influenza is recommended each year.
- I understand that I cannot get influenza from the influenza vaccine.
- The consequences of my refusing to be vaccinated could have life-threatening consequences to my health and the health of those with whom I have contact, including all patients in this healthcare facility, coworkers, my family and my community.

Because I have refused vaccination against influenza, I will be required to wear surgical or procedure masks in areas where patients or residents may be present during the influenza season.

Face Mask Provided:

Signature:_____ Date: _____

I acknowledge that I have read this document in its entirety and fully understand it. Despite these facts, I have decided to decline the influenza vaccine by my signature below. I realize that I may re-address this issue at any time and accept vaccination in the future.

Signature of Employee: _____ Date: _____

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HIV[1] CONFEDENTIALITY

I_____understand that while working as an Employee for S&A Unified Home Care, I may care for, have contact with, and/or have access to confidential records of HIV positive clients. I acknowledge that such clients may not be discriminated against and that information as to their HIV positive status is protected by New York State Law.

S&A Unified Home Care has advised me that New York State Law prohibits me from making any further disclosure of such confidential information without the specific written concern of the person to whom it pertains (or of their legal guardian, Designated Representative, or by a Court order), or as otherwise permitted by law, and that any unauthorized further disclosure in violation of state law may result in fine, jail sentence or both.

I understand that a general authorization for the release of medical and or other information is not sufficient authorization for further disclosure of such information pursuant to a general authorization for the release of medical or their information violates New York State Law and may result in a fine, jail sentence or both.

I understand that failure to comply with the foregoing violates both New York State Law and S&A Unified Home Care policy and such failure shall be just cause for immediate termination. I further understand that any breach of confidentiality of HIV positive client records in punishable by fine and or imprisonment.

DRUG TESTING POLICY

As part of your application process or during the course of your employment with S&A Unified Home Care, Inc., as requires by law, you may be subject to drug and/or alcohol testing. You have the right to decline to complete any test required. However, refusal to comply with these test requirements will result in immediate termination of your employment with S&A Unified Home Care, Inc. Furthermore, applicants who attempt to alter their test results in any way will no longer be considered for employment. Current employees who attempt to alter their test results will be terminated at once.

I,_____, do hereby declare that I am free from illegal drugs and improper use of prescription drugs or alcohol. I acknowledge that a positive test result will constitute cause for denial or termination of employment at S&A Unified Home Care, Inc. I understand what I am being tested for and the procedure involved, and I do hereby freely give my consent.

I understand, agree and will comply with S&A Unified Home Care HIV Confidentiality and Drug Testing Policy.

Employee Signature:_____ Date: _____

RN Signature:_____ Date: _____

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HEPATITIS B VACCINE
CONSENT/DECLINATION FORM

EMPLOYEE FULL NAME: _____

I acknowledge that I am at risk of exposure or have been unknowingly exposed to the Hepatitis B virus as a result of my employment and acknowledge that the agency will arrange for me to receive the Hepatitis B vaccine. I have read the information sheet concerning the disease, the vaccine and possible adverse reactions to the inoculation. Additionally, I have asked any questions which I may have had and they have been fully answered to my satisfaction. I hereby make the decision to:

- ☐ **Refuse the Hepatitis B vaccine** and hold harmless the agency. I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring the Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with the Hepatitis B vaccine, at no charge to myself. However, I decline the Hepatitis B vaccination at this time. I understand that by declining the vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If, in the future, I continue to have occupational exposure to blood or other potentially infectious materials and want to be vaccinated with the Hepatitis B vaccine, I can receive the vaccination series at no charge to me.
- ☐ I'm immune and able to provide proof by request
- ☐ I have a medical contraindication and able to provide proof by request
- ☐ I request to receive the Hepatitis B vaccine.

Employee Signature:_____ Date: _____

RN Signature:_____ Date: _____