Declination of Influenza Vaccination

My employer or affiliated health facility, The Language Banc, has recommended that I receive influenza vaccination to protect the patients I serve.

I acknowledge that I am aware of the following facts:

- Influenza is a serious respiratory disease that kills thousands of people in the United States each year.
- Influenza vaccination is recommended for me and all other healthcare workers 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, even if my symptoms are mild or non-existent, I can spread it to others and they can become seriously ill.
- I understand that the strains of virus that cause influenza infection change almost every year and, even if they don't change, 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
  - my coworkers
  - my family
  - my community

Despite these facts, I am choosing to decline influenza vaccination right now for the following reasons: _____

_____

_____

I understand that I can change my mind at any time and accept influenza vaccination, if vaccine is still available.

I have read and fully understand the information on this declination form.

Signature: _____ Date: _____

Name (print): _____

Department: Fairview Language Services

Reference: CDC. Prevention and Control of Influenza with Vaccines—Recommendations of ACIP at www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/flu.html

Technical content reviewed by the Centers for Disease Control and Prevention

IMMUNIZATION ACTION COALITION Saint Paul, Minnesota • 651-647-9009 • www.immunize.org • www.vaccineinformation.org

www.immunize.org/catg.d/p4068.pdf • Item #P4068 (8/14)

FAIRVIEW
2450 Riverside Avenue South
Minneapolis, MN 55454
www.fairview.org

Certificate of Completion

Thank you for completing Fairview Health Services online Required Learning for Temporary Agency Staff accepting work assignments with us.

Please fill out the form below with your personal information and print a copy. After the certificate is generated please sign and give to your employer to be placed in your Human Resource file.

Full Name:	
Agency:	The Language Banc
Department/Unit Assignment:	Fairview Language Services
Date (mm/dd/yy):	

_____

Signature

RightSourcing

AUTHORIZATION RELEASE FORM

I, _____, understand that I may be assigned to perform services for Fairview Health Services ("Client"). I further understand that, for business purposes, it may be necessary for my Employer, Client and RightSourcing, Inc. ("RightSourcing") to maintain and exchange certain personal information about me, including my social security number, date of birth, and the items listed below. RightSourcing and Client will use this information for verification purposes only. RightSourcing is requesting this information as an agent of Client. This completed form must be sent directly to my Employer, who will forward it to RightSourcing.

Therefore, I _____, authorize Client and RightSourcing to maintain and exchange personal information about me, including but not limited to, my social security number, date of birth, and the items listed below. I further authorize the transfer from my Employer, prior to the performance of my assignment at Client, such personal information to RightSourcing and Client. I understand and agree that such information may be used for business purposes relating to my assignment to perform services for Client. I waive and release any claims I may have relating to the exchange or use of such information by Client and RightSourcing. I understand such information will be stored in RightSourcing's vendor management system.

I understand that this authorization is voluntary. I understand that my health information may be protected by the Federal Rules for Privacy of individually Identifiable Health Information and/or state laws. The release of this information may no longer be protected by the Federal privacy regulations.

Below is list of items that may I voluntarily give authorization to share with the aforementioned parties:

(Privacy)	(Medical Documents)
County Criminal Search	Drug Screen Results, 5-Panel: Marijuana (THC), Amphetamines including Methamphetamine, Cocaine, Opiates and Phencyclidine (PCP)
National Criminal Database Search	Drug/Alcohol Screen Results, 5-Panel: Marijuana (THC), Amphetamines including Methamphetamine, Cocaine, Opiates and Phencyclidine (PCP) including Alcohol Screening
Social Security Trace	Physical Exam
DMV Search	Tuberculosis Testing
Office of the Inspector General (OIG)	Annual Flu Vaccination (Influenza)
System for Award Management (SAM)	Hepatitis B
Department of Human Services (DHS)	TDAP (Pertussis) *Optional
148A Reporting Form	Measles, Mumps, Rubella (MMR)
Photo Identification	Varicella
	N-95 Fit Test
	Color Vision Screening
	Fairview Question Sheet

RightSourcing

AUTHORIZATION RELEASE FORM

AUTHORIZATION:
I certify that this request has been made freely, voluntarily and without duress or coercion of any kind or nature whatsoever. I understand that I may request a copy of this form after I sign it. I understand and agree that I have had the right and opportunity to consult with legal counsel of my choice in connection with my execution of this Authorization. I may revoke this authorization, in writing, at any time except to the extent in reliance of my authorization and my information has already been released to RightSourcing or Client. Written revocation is effective upon receipt by the below listed Employer of record. Without my express revocation, this authorization will not expire until my assignment at Client has ended or has been terminated.

Signature: _____ Print Name:_____ Date: _____

Employer ("Employer"): The Language Banc

FAIRVIEW

Fairview Health Services

Employee Occupational Health Services

Hepatitis B Questionnaire/Declination for Non Employees

Name _____ **Date of Birth** _____
(Please Print)

Job Title Interpreter

☒ I do not wish to receive the Hepatitis B vaccine at this time.
(Please sign declination below)

DECLINATION

(OSHA 1910.1030, App A)

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis vaccine, at no charge to Fairview employees. However, I decline Hepatitis B vaccination at this time. I understand by declining this 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 I want to be vaccinated with Hepatitis B vaccine, I can complete the vaccination series at no charge to Fairview employees.

Signature _____ **Date** _____

FAIRVIEW

Confidentiality Agreement

CONFIDENTIALITY AGREEMENT

I may become aware of confidential information as part of my association with Fairview. The confidential information may be in written, oral or electronic form and may include private information about a patient or employee, or pertain to financial, business, scientific or research matters. Fairview expects that any discussion, access, storage, interpretation, release or handling of confidential information will be treated with care and caution. I understand that any breach of confidentiality is a violation the privacy policies of Fairview Health Services and will be dealt with immediately.

Name: (Please Print)_____

Fairview Location: Fairview Language Services/All Location

Date: _____

Signature: _____

HIPAA - Confidentiality Agreement

Form #530026e Sep '03

RightSourcing

Tuberculosis Screening Questionnaire

This document is required and completed on an annual basis for all roles that require TB Testing.

Name (Please Print)	
Today's Date	
Positive TB Skin Test (PPD) Date (if Applicable)	
Last Chest Xray Date -related to positive PPD (if Applicable)	

Please indicate if you are having any of the following problems for three to four weeks or longer:

1. Chronic cough (greater than 3 weeks) Yes _____ No _____
2. Production of Sputum Yes _____ No _____
3. Blood-streaked Sputum Yes _____ No _____
4. Unexplained weight loss Yes _____ No _____
5. Fever Yes _____ No _____
6. Fatigue/Tiredness Yes _____ No _____
7. Night sweats Yes _____ No _____
8. Shortness of Breath Yes _____ No _____

Date		Agency Employee Signature	

Revised: 4.3.15