

COVID-19 Vaccination Declination for 2024/2025 Respiratory Virus Season

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| **NAME** | **EMPLOYEE NUMBER (if applicable)** |
| **CAMPUS**   * MCSS ☐LBMC ☐MCWHLB ☐OCMC ☐SMC ☐MCMF | **DEPARTMENT (if applicable)** |
| **CATEGORY**   * Employee ☐LIP/Physician ☐Volunteer ☐Student/Resident ☐Contractor ☐Registry ☐Other | |

On October 3, 2024, the City of Long Beach Health and Human Services aligned with the Los Angeles County Department of Public Health (“LACDPH”) Health Officer Order requiring healthcare providers (“HCPs”) receive an updated COVID-19 vaccine (2024-2025 Formula) prior to or during the respiratory virus season, annually defined as November 1, 2024 to April 30, 2025, or wear a respiratory mask while in contact with patients or working in patient-care areas. In addition, HCPs who decline the updated vaccine must provide their employer, on a form provided by their employer, a written declaration that they have declined the updated COVID-19 vaccination. In compliance with LACDPH and the Long Beach Department of Health and Human Services, please complete the information below.

Declination of COVID-19 Vaccination

# I have already had the COVID-19 vaccination (2024/2025 formula) and provided proof for the 2024-2025 respiratory virus season.

* **I have declined to receive the COVID-19 vaccine for the 2024-2025 respiratory virus season.**

**I acknowledge that I am aware of the following:**

* CDC recommends that everyone ages 6 months and older receive one dose of the updated (2024–2025 Formula) COVID-19 vaccine.
* If I am unable to receive the COVID-19 vaccine at this time due to illness or recovering from an illness, and I receive the vaccination at a later date, I can submit proof of vaccination at that time.
* If I have not provided proof of vaccination, I must wear a respiratory mask (i.e., surgical, procedural mask with ear loops) or higher-grade mask during the respiratory virus season starting November 1, 2024, and ending April 30, 2025.

# I CHOOSE TO DECLINE the COVID-19 vaccination at this time. I will wear a respiratory mask as indicated above while in contact with patients and/or working in patient-care areas.

**Signature: Date:**

**Form must be returned to HR for employees; to the Medical Staff Office for AHPs; and to the Volunteer Office for volunteers.**

10/4/24