**Employee Vaccination Refusal Waiver**

I, the undersigned staff member of National Ambulance, declare my refusal to receive the following vaccination/s:

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Due to (specify your reasons for refusal) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that the vaccination/s is/are essential in protecting me from communicable diseases that I might be exposed to while in performance of my duty.

Staff Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Staff Signature/ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Director: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date (dd/mm/yy): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature & Stamp/ ID