



Influenza Vaccination Form

Las Palmas Del Sol Healthcare is committed to the health and safety of our patients, colleagues and community. As part of our action plan for Influenza, we are raising awareness of the HCA Healthcare policy on Communicable Disease which states:

"Colleagues who believe they are infected with the flu or another communicable illness that can be transmitted through ordinary workplace contact are strictly prohibited from coming to work."

By signing this form below, you are **attesting** to your compliance to self-screen for communicable illness prior to reporting to our facilities and that you are symptom free. This requirement extends to our affiliated schools and their students.

Please complete the information requested below and e-mail to:

ELPS.ClinicalRotation@HCAHealthcare.com

School: _____

Campus: Las Palmas Del Sol Both

Basic Information:

Legal Last Name:	
Legal First Name:	
Middle Name:	
SSN (Last 4 Digits):	
Date of Birth (Month/Date/Year)	

Contact Information:

Preferred Phone Number:	
Preferred E-mail Address:	

Relationship to HCA-Affiliated Facilities: Non-Employee Student

Additional Work Information: I am paid by an HCA Organization: Does Not Apply

Flu Vaccination:

<input type="checkbox"/> I consent to receive the Influenza Vaccine
<input type="checkbox"/> I decline to receive the Influenza Vaccine
<input type="checkbox"/> I already received the Influenza Vaccine

Signature:

Signature:	
Printed Name:	
Date:	