

INFLUENZA VACCINE VERIFICATION 2018

Instructions: Use this form when providing a medical record indicating you received the influenza vaccination from your healthcare provider, pharmacy or clinic. All fields are mandatory and must be completed, including signature, in order for your form to be processed. You must print clearly. You must submit a medical record with this form indicating you received the influenza vaccination. The medical record must include your name, the date vaccine was administered, the healthcare provider, pharmacy or clinic information, the name and signature of the healthcare provider who administered the vaccine. Fax completed form and medical record to 847-763-8656. Influenza Vaccine Verification forms submitted without a medical record cannot be processed.

Name:		Date:	
Employee ID:		Last 4 Digits of SSN:	
Department:			
Email:		Cell Phone:	
Employee <input type="checkbox"/> Volunteer <input type="checkbox"/> Student <input type="checkbox"/> Intern <input type="checkbox"/> Resident <input type="checkbox"/> Physician <input type="checkbox"/> Other <input type="checkbox"/> _____			
Check all locations that apply: Evanston <input type="checkbox"/> Glenbrook <input type="checkbox"/> Highland Park <input type="checkbox"/> Skokie <input type="checkbox"/> Medical Group <input type="checkbox"/> 1301 Central <input type="checkbox"/> 4901 Searle <input type="checkbox"/> Other <input type="checkbox"/> _____			

I have read the Vaccine Information Statement about the influenza vaccine located on PULSE, employeeConnect and/or northshore.org. I acknowledge that the information I am providing is true to the best of my knowledge and that knowingly submitting a false record will result in disciplinary action up to and including termination. I recognize that the influenza vaccine may not prevent me from developing the specified disease. I also recognize there is a remote possibility that I could experience an adverse side effect from the immunization.

If I have an EPIC record at NorthShore University HealthSystem, I also consent that my EPIC record will be updated to indicate I have had the flu shot.

Check the box if you consent to have your EPIC record updated to indicate you had the flu shot.

Signature:	Date:
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