Medical Exemption Request

Covid-19 Vaccination – States outside of California

Colleague Information – *To be completed by employee*

Printed Name: **3-4 ID:**

Date: **Date of Birth:**

If you wish to request a medical exemption from mandatory vaccination, please sign the attestation below:

I have a medical condition or disability that prevents me from taking any of the COVID-19 vaccines authorized by the FDA. To be eligible for this exemption, I understand that I must provide to my employer (or to the facility where I volunteer or otherwise work) a written statement signed by my licensed healthcare provider, that I qualify for the exemption and indicating the probable duration of my inability to receive the vaccine (or indicating that the duration is unknown).

Employee Signature: _____ Date: _____

Please note, as a part of the exemption quality process, there may be follow-up review of this exemption. You will receive an email notifying you of approval/declination of your request. If you have questions regarding your request, reach out to your human resources representative. If this request is approved, you will be required to practice universal masking in the workplace unless actively eating or drinking. Please follow local or state and/or facility guidance for testing as part of this exemption. If your request is denied, you will either need to receive the COVID-19 vaccination or employment will be terminated.

Healthcare Provider Information – *To be completed by healthcare provider*

Printed Name: **Provider Specialty:**

NPI: **Phone Number:**

Licensed Healthcare Provider: Please mark the contraindications / precautions or other medical condition / disability that apply to this patient and sign and date this form. Licensed Healthcare Provider must include either a treating physician (M.D. or D.O.) or treating advanced practice professional (nurse practitioner or physician assistant). **Note: Health Care Providers cannot sign their own exemption / certification request.**

Vaccine Contraindication Certification (list all that apply) –
Requires healthcare provider signature

Note – Contraindication to one vaccine does not preclude receipt of another vaccine type	
Johnson & Johnson	☐ Known history of severe allergic reaction (anaphylaxis) to any component of the vaccine or immediate allergic reaction ☐ Previous history of heparin-induced thrombocytopenia (HIT) ☐ History of Guillain-Barre Syndrome post-vaccine ☐ Contraindication to MRNA vaccines (must specify below) AND female under age of 50 ☐ My patient has a physical or mental impairment that substantially limits one or more major life activities and prevents the patient from safely receiving the vaccine. (More detail regarding the medical condition and how it prevents the patient from receiving the vaccine must be attached). Additional Information:
mRNA Pfizer or Moderna	☐ Known history of severe allergic reaction (anaphylaxis) to any component of the vaccine or immediate allergic reaction ☐ Known history of severe reaction (anaphylaxis) to the first dose of either mRNA vaccine ☐ Previous history of Multisystem Inflammatory Syndrome (MIS) of adults or children ☐ Documented Myocarditis after first dose of mRNA vaccine ☐ My patient has a physical or mental impairment that substantially limits one or more major life activities and prevents the patient from safely receiving the vaccine. (More detail regarding the medical condition and how it prevents the patient from receiving the vaccine must be attached). Additional information:
Deferral Certification – *Requires healthcare provider signature*	

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General (Request for Deferral)	☐ Acute COVID-19 infection documented in the past 90 days ☐ Receipt of monoclonal/polyclonal COVID-19 antibody treatment within the past 90 days ☐ Receipt of high titer COVID-19 antibody treatment (Convalescent Plasma) within the past 90 days **Deferral timeframe needed from provider for when employee can receive vaccination.** **Date employee can be vaccinated:** Additional information:

I attest that I have a healthcare provider-patient relationship with the employee identified above and that the above statements are true and accurate.

Healthcare Provider Signature: _____ **Date:** _____

For internal use only:
(Post-initial review)
This form is:

- ☐ **Complete**
- ☐ **Incomplete**

Internal review date (if applicable):

Comments:

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