Medical Exemption Request

Covid-19 Vaccination – Colorado

Colleague Information

Printed Name: 3-4 ID:

Date:

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 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: _____

Healthcare Provider Information

Printed Name: Provider Specialty:

License Number: 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 or certified nurse midwife). **Note: Health Care Providers cannot sign their own exemption / certification request. *Providers are also subject to randomized review following the submission of exemption request from the patient. ***

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) ☐ Contraindication to MRNA vaccines (must specify below) AND female under age of 50 ☐ Other _____ (must provide specifics)

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 ☐ Other _____ (must provide specifics)
Deferral Certification – *Requires healthcare provider signature*	
General (Request for Deferral)	☐ Acute COVID-19 infection. Vaccination will be received once individual has recovered from acute illness if symptomatic and met requirements to discontinue isolation. ☐ Receipt of monoclonal/polyclonal COVID-19 antibody treatment within the past 90 days* ☐ Receipt of convalescent plasma treatment within the past 90 days* *Deferral timeframe needed from provider for when employee can receive vaccination. * **Date employee can be vaccinated: _____**

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

Healthcare Provider Signature: _____ Date: _____

This exemption request has been:

☐ **Approved**

☐ **Denied**

If your request is approved, you will be required to participate in mitigation practices as required by your Hospital. If you request is denied, you will be notified by Human Resources.