

COVID19 Medical Exemption Request Form rev 2-28-22
For use in States outside of California

Verified Professional Information–To be completed by self only (delegates may not sign for the VPro)

Verified Professional's Printed Name		Date	Month	Day	Yr
3-4 ID: <i>If applicable</i>					

INSTRUCTIONS: Carefully read information below regarding masking expectations of you when accessing HCA Healthcare sites. Your completion of this form and your signature is required wherever noted on this form. Incomplete forms, will be rejected. We appreciate your understanding and cooperation with this patient safety compliance initiative.

HCA Healthcare and HealthTrust Workforce Solutions Verified Professionals strongly recommends that all healthcare workers receive the COVID-19 vaccination series. However, if you have been granted an exemption, there are certain requirements that must be adhered to while in the clinical setting.

Protect yourself and others by maintaining distance from others whenever possible. **Unvaccinated healthcare workers must wear an approved respirator in all clinical areas.**

Respirator: A respirator is a personal protective device that is worn on the face, covers at least the nose and mouth, and is used to reduce the wearer’s risk of inhaling hazardous airborne particles (including dust particles and infectious agents), gases, or vapors. Respirators, including those intended for use in healthcare are certified by the CDC/NIOSH.

- Wearing this mask is required for those who are unvaccinated against COVID-19.
- Guidance for non-fit-tested N-95 Respirators can be found using the link in Resource section of this email communication.
- It is recommended that unvaccinated healthcare workers not care for immunocompromised patients.
- Unvaccinated and fully vaccinated healthcare workers should continue to universally mask while at work for source control, maintain appropriate physical distancing while interacting with coworkers, and follow the recommended transmission-based precautions while caring for patients or residents.
- If you are feeling ill, please stay home. Do not report to work if you have any signs consistent with COVID-19 (measured or subjective fever) or symptoms (e.g., cough, shortness of breath, sore throat, muscle aches, headache, loss of taste or smell). If you develop fever or respiratory symptoms at work, isolate yourself immediately, leave work and report symptoms to your supervisor or occupational health services before departure.
- Refer to your facility policy for specific guidance.
- Even after receiving an exemption approval, you may decide to receive your vaccination. Please visit <http://www.vaccines.gov> to find a vaccination location near you.

Signature by Verified Professional		Date	Month	Day	Yr

- **Please note, as a part of the exemption quality process, a secondary review of your exemption request may occur, and you may be contacted for additional follow-up. If this request is approved, you will be required to practice universal masking or wear an approved respirator in all clinical areas (as noted on page 1) in the workplace unless actively eating or drinking.**
- **If your request form is denied, you will be informed.**

Resources:

- OSHA - Protecting Workers: Guidance on Mitigating and Preventing the Spread of COVID-19 in the Workplace- <https://www.osha.gov/coronavirus/safework>
- CDC – COVID-19 - <https://www.cdc.gov/coronavirus/2019-ncov/index.html>
- CDC – Clinical Care Information for COVID-19 - <https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-care.html>

COVID19 Medical Exemption Request Form rev 2-85-22
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Verified Professional’s Information – To be completed by self only (delegates may not sign for VPro)

Verified Professional’s Printed Name		Date	Month	Day	Yr
3-4 ID: <i>if applicable</i>					

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).

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 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 access will be terminated.

Signature by Verified Professional		Date	Month	Day	Yr

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Healthcare Provider Information – All sections of this form must be completed by the healthcare provider
All information must be completed

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. *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	<input type="checkbox"/> Known history of severe allergic reaction (anaphylaxis) to any component of the vaccine or immediate allergic reaction
	<input type="checkbox"/> Previous history of heparin-induced thrombocytopenia (HIT)
	<input type="checkbox"/> History of Guillain-Barre Syndrome post-vaccine
	<input type="checkbox"/> Contraindication to mRNA vaccines (must specify below) AND female under age of 50
	<input type="checkbox"/> 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	<input type="checkbox"/> Known history of severe allergic reaction (anaphylaxis) to any component of the vaccine or immediate allergic reaction
	<input type="checkbox"/> Known history of severe reaction (anaphylaxis) to the first dose of either mRNA vaccine
	<input type="checkbox"/> Previous history of Multisystem Inflammatory Syndrome (MIS) of adults or children
	<input type="checkbox"/> Documented Myocarditis after first dose of mRNA vaccine
	<input type="checkbox"/> 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:

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All sections of this form must be completed by the healthcare provider
All information must be completed

Deferral Certification – Requires healthcare provider signature			
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	
	<p><i>*Deferral timeframe needed from provider for when colleague can receive vaccination.*</i></p> <p><i>*Colleague refers to Vendor/Verified Professional/Clinician/Etc. who is credentialed with HealthTrust VPro or Workforce 2.0</i></p>		
	<p>Date Verified Professional can be vaccinated: To be completed by Healthcare Provider Only</p>	Month	Day
Additional information:			

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

Healthcare Provider Signature:			
Healthcare Provider Printed Name:			
Date:	Month	Day	Year