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COVID19 Vaccination Exemption Request Form – Except California

Pursuant to federal, state, local order(s) and/or facility policy, one of the facilities you are requesting access to is requiring proof of full vaccination. The rule indicates that all employees, direct contractors and support staff working in these facilities must get the COVID-19 vaccine, unless they have submitted and been approved for a valid, documented medical or religious exemption. All required individuals must be fully vaccinated against COVID-19 unless an exemption has been approved. Failure to become vaccinated or secure an exemption will impact your ability to work.

As required by the rule, as well as state and federal law, reasonable accommodations will be provided to colleagues who have a medical condition or religious belief which prohibits them from receiving the COVID-19 vaccination. Any colleague wishing to request an accommodation, and therefore an exemption from the vaccine mandate, must complete this form and submit it for consideration**.**

- **Please follow local or state and/or facility guidance for testing and/or universal masking in the workplace as part of this exemption.**
- **Please note, as a part of the exemption quality process, a secondary review of the exemption may occur and you may be contacted for additional follow-up.**
- **If your request is denied, you will either need to receive the COVID-19 vaccination or you will not be able to work at the facility and your access would be terminated.**

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Medical Exemption Request

Covid-19 Vaccination (except California)

Colleague Information – *To be completed by employee/contactor*

Printed Name:		**3-4 ID:** *If applicable*	
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 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.

Colleague Signature:		**Date:**	

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Medical Exemption Request

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

All information must be completed

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		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:	

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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
	Deferral timeframe needed from provider for when colleague can receive vaccination.	
	Date colleague can be vaccinated:	
	Additional information:	

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

Healthcare Provider Signature:	
Date:	