**Covid-19 Vaccine - Medical Exemption Request**

**(Company Name)**

*This company is committed to diversity and inclusiveness of all our employees.  The company is also committed to safe conditions for customers and staff and has mandated COVID-19 vaccination for certain staff (check with legal counsel if mandating COVID-19 vaccines as the EEOC has not clearly indicated that these should be mandated while under an emergency authorization.)  If you have declined to receive a vaccine for medical reasons, please provide the following information (complete all sections).*

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| Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *I request a medical exemption from the COVID-19 vaccination. I hereby affirm that I am declining vaccination at this time because I have a medical condition which is recognized as described below to have potential adverse impacts from the vaccine. I understand that this form must be completed and returned to the Human Resources Department by the published deadline. I also understand that if I am granted an exemption, a discussion will continue related to alternative methods to maintaining a safe environment. If I am not granted an exemption, I must receive the vaccination as required.  Otherwise, the company may choose to take disciplinary action, put me in a more suitable role, place me on unpaid leave or terminate my employment.*    Individual’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

*This section below is to be completed by the employee’s physician:*

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| The CDC and health departments all advise that the best way to prevent communication and spread of COVID-19 is vaccination and this company is choosing to require vaccines for certain positions.  The individual named above has requested a medical exemption. Please complete the bottom portion of this form so that we may consider this request. Failure to provide information below may result in exemption denial. If you have questions, please contact our HR Department for assistance.  **Physician Certification of Contraindication**  My signature below indicates that I have reviewed the guidance for medical exemptions (contraindications) related to COVID-19 maintained by the CDC here: <https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html> AND that having considered all options for vaccination for COVID-19, I certify that the following medical contraindications prevent this individual from safely receiving a vaccination.  **The following are NOT considered contraindications to COVID-19 vaccination as of the time of this form’s creation (however, the link above is the CDC’s most up-to-date information):**  • Local injection site reactions after (even delayed after) previous COVID-19 vaccines (erythema, induration, pruritus, pain, etc.)  • Expected systemic vaccine side effects in previous COVID- 19 vaccines (fever, chills, fatigue, headache, lymphadenopathy, vomiting, diarrhea, myalgia, arthralgia)  • Being an immunocompromised individual, having immunocompromising conditions or receiving immunosuppressive medications, as well as Bell’s palsey and Guillain-Barre syndrome (GBS).  • Allergic reactions to anything not contained in the COVID-19 vaccines, including injectable therapies, food, pets, venom, environmental allergens, oral medication, latex, etc  • Breastfeeding, pregnancy and/or those trying to get pregnant.  • Immunosuppressed person in the employee’s household  • The COVID vaccines do not contain egg or gelatin and related allergies are not a contraindication.  **Indicate contraindication for this individual below:**   * Severe allergic reaction (anaphylaxis) after a previous dose of or to a component of the COVID- 19 Vaccine, including Polyethylene Glycol (PEG) (Describe contraindication if necessary to alternatives, for example Johnson & Johnson vaccine is free of PEG) * Immediate allergic reaction of any level of severity to a previous dose or known (diagnosed) allergy to a component of the vaccine (Describe contraindication if necessary to alternatives, for example Johnson & Johnson vaccine is free of PEG) * Other medical circumstance preventing vaccination with any available COVID-19 vaccine (Be specific & describe in detail below)   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Patient name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Physician signature (required) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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Please send completed form to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ by 5pm on \_\_\_\_\_\_\_\_\_\_\_  via email \_\_\_\_\_\_\_\_\_\_\_\_\_          or fax: \_\_\_\_\_\_\_\_\_\_\_\_\_