Nursing Home Request for Medical Exemption from COVID-19 Vaccination

The _____ State Department of Health (DOH) and Centers for Medicare and Medicaid Services (CMS) have mandated the COVID-19 vaccine for staff in hospitals and nursing homes, except in the case of limited exemptions for medical reasons or sincerely held religious beliefs.

This form is for employees seeking a medical exemption from this mandate; a licensed physician or certified nurse practitioner must certify that immunization with COVID-19 vaccine would be contraindicated for the employee based on current guidelines of the Centers for Disease Control and Prevention (CDC).

Submitting this request does not guarantee approval. If approved, medical exemptions expire when the medical condition(s) contraindicating COVID-19 vaccination changes in a manner which permits immunization.

If the approved exemption expires, you will be expected to commence the COVID-19 vaccine requirement. Should the condition continue, a new immunization contraindication occur, or the current exception expire, a new request with updated documentation is required.

By signing below, I acknowledge that:

1. I am requesting an exemption from the COVID-19 vaccine requirement due to my current medical condition.
2. I have read *(the facility's)* Employee COVID-19 Vaccination Policy.
3. I understand and assume the risks of not being vaccinated in the workplace.
4. I understand that I may be required to follow certain protocols or be offered temporary alternative accommodations in the workplace, which may be subject to change in pay/hours if my exemption request is approved.
5. I understand that any approved exemption is based on *(the facility's)* current COVID-19 Employee Vaccination Policy and is subject to change based on *(the facility's*) requirements in the future.
6. I certify that the information I have provided in connection with this request is accurate and complete as of the date of submission.
7. I understand that the exemption may be revoked, or I may be subject to discipline if any of the information provided in support of this request is false.
8. I authorize my licensed health care provider to release the necessary medical information to *(the facility)* for purposes of determining whether I qualify for an exemption for the COVID-19 vaccine.
9. I authorize *(the facility's)* Human resource Department or Employee Health Service to seek clarification of any documentation provided, if necessary, by contacting my health care provider directly.
10. I understand that the contents of this request are confidential and will only be shared as needed with the appropriate *(Facility)* personnel to consider the exemption and the impact of an approval on operations.
11. I acknowledge that regular COVID testing and compliance with all COVID-19 protocols will be required for my continued employment.

I declare that the statements, documents, and information provided herein are true and accurate. I acknowledge that fraudulently submitting or fraudulently obtaining an exemption under this process will subject me to disciplinary action, up to and including termination of employment.

_____ _____

Employee Signature Date

Employee Name: _____

To Be Completed by Healthcare Provider:

This section must be completed by the employee's health care provider (licensed physician or certified nurse practitioner), who is appropriate for the associated medical condition.

Attention Health Care Provider,

_____ (employees name) is requesting a medical exemption from this vaccination requirement. A medical exemption may be allowed for certain recognized contraindications. Please certify below the medical reason that your patient should not be vaccinated for COVID-19 by completing this form and attaching available supporting documentation.

OPTION 1 – Adverse Reaction to Previous Dose

☐ Patient has a documented history of a severe adverse reaction (e.g., anaphylaxis, myocarditis) to any component of a COVID-19 vaccine or to a substance that is cross-reactive with a component.

NOTE:

- Since egg-free vaccine is available, history of egg allergy will not be accepted as a routine medical exemption
- If an individual has a documented allergy to Polyethylene Glycol, they can receive the Johnson & Johnson (J&J) vaccine instead, and the staff member should be advised to seek vaccination with the J & J vaccine.

Please indicate which of the following vaccines are contraindicated and name the components, by vaccine.

☐Moderna –list the component(s): _____

☐Pfizer –list the component(s): _____

☐Janssen/Johnson & Johnson –list the component(s): _____

☐ Patient has a documented history of a severe adverse reaction after a previous dose of the COVID-19 vaccine. Please indicate the nature of the reaction, to which vaccine the patient had a reaction, the date of the vaccine, and the date of the reaction.

☐Moderna –date of vaccine and date of reaction:

_____

☐Pfizer –date of vaccine and date of reaction:

_____

☐Janssen/Johnson & Johnson – date of vaccine and date of reaction:

_____

OPTION 2 – Active Myocarditis

☐ Staff may delay vaccination until myocarditis has fully resolved and approved by staff member's cardiologist.

OPTION 3 – Active COVID Infection

☐ Patient has Active COVID-19 infection- vaccination should be delayed until staff member is fully recovered from infection and no longer in isolation, not to exceed 90 days from date of positive Covid-19 test.

OPTION 4 – Monoclonal Antibodies in the past 90 Days (or 30 days if given prophylactically)

☐ Patient has received monoclonal antibodies within the past 90 days (or 30 days if given prophylactically).

If yes, name the medication and date of administration: _____

If yes, end date of requested exemption: _____

PRACTITIONER CERTIFICATION

I certify that _____ (patient name) has the above contraindication and support the request for a medical exemption from the COVID-19 vaccine as a condition of employment requirement at (*FACILITY NAME*). I further certify that I am in an on-going professional relationship with the patient for the condition indicated above and have not been engaged for the sole purpose of providing this exemption.

Health Care Practitioner Signature: _____ Date: _____

Printed Name: _____ Practitioner License Number: _____

Specialty or Practice:_____ Practitioner Phone #:_____

Email: _____

Office Address: _____