Infection Prevention and Control
COVID-19 Vaccine Medical Exemption Form (Sample)

This facility will consider granting an employee a medical exemption from the COVID-19 Vaccination based upon an authenticating practitioner's recommendation (who is not the person requesting the exemption) based on the recognized clinical contraindication(s).

To request the medical exemption from vaccination, please complete Section 1 below and have your medical provider complete Section 2 before returning this to Occupational Health

SECTION 1

Employee Name: _____ Department**:** _____

Employee Signature: _____ Date: _____

SECTION 2

Medical Certification for Vaccine Exemption

Dear Medical Provider,

This facility requires vaccination against COVID-19 as a condition of employment. The individual named above is seeking an exemption to this policy due to medical contraindications.

Please complete this form to assist the facility in the reasonable accommodation process.

Describe the recognized clinical contraindications to the COVID-19 Vaccine(s):

- ☐ Employee received monoclonal antibodies for post-exposure prophylaxis in the past 30 days
- ☐ Employee received monoclonal antibodies for COVID-19 treatment in the past 90 days
- ☐ Employee received convalescent plasma for post-exposure prophylaxis in the past 30 days
- ☐ Employee received convalescent plasma for COVID-19 treatment in the past 90 days
- ☐ Employee has a history of thrombocytopenia syndrome (TTS) following 1 dose of Janssen COVID- 19 Vaccine (Address in comment section if another COVID-19 vaccine is not indicated)
- ☐ Employee has a history of myocarditis or pericarditis after a dose of an mRNA COVID-19 vaccine
- ☐ Employee has a history of Guillain-Barré Syndrome (GBS) and an mRNA COVID-91 vaccine is not available
- ☐ Employee had a severe allergic reaction (e.g., anaphylaxis) following a previous dose or a component of the COVID-19 vaccine
- ☐ Employee has a contraindication to one type of a COVID-19 vaccine
- ☐ Immediate (within 4 hours) non-severe allergic reaction to a previous dose or known (diagnosed) allergy to a component of the vaccine
- ☐ Immediate allergic reaction to any other vaccine or injectable therapy
- ☐ Other (describe): _____

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This exemption should be:
☐ Permanent
☐ Temporary, expiring on: __/__/____, or when _____

****Attach supporting medical information**

I certify the information provided to be true and accurate, and request exemption from the COVID-19 vaccination for the above-named individual.

Medical Provider Name (print):	
Medical Provide Signature:	Date:
Practice Name & Address:	Provider Phone:

Occupational Health Signature: _____ Date Received: _____

Medical Exemption Granted: Yes: _____ No _____ Date: _____

Comments: _____

_____

Occupational Health Use Only:

Medical Exemption Granted: Yes: _____ No _____ Date: _____

Details of Approval: _____

Medical Exemption Denied: Yes: _____ No _____ Date: _____

Details of Denial: _____

Follow up Action Taken: _____

***This exemption will be kept in the employee's personnel file

Resource and Reference:

Centers for Medicare & Medicaid Services. QSO 22-07-All. Long-Term Care and Skilled Nursing Facility Attachment A: https://www.cms.gov/files/document/qso-22-07-all-attachment-ltc.pdf