**MANDATORY IMMUNIZATION – MEDICAL EXEMPTION REQUEST**

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| --- | --- | --- | --- |
| **Requestor Name:** |  | **Phone (Primary):** |  |
| **Date of Birth:** |  | **Phone (Alternate):** |  |

Medical exemptions may be granted for recognized contraindications.

**INSTRUCTIONS:**

1. Complete and sign this page.
2. Schedule an appointment with your Primary Health Care Provider and present them with the Healthcare Provider Form to complete.
3. Return completed Documents to WHMS by:

a. Emailing [thornburgk@westholtmed.org](mailto:thornburgk@westholtmed.org)

b. Faxing to 402-925-2914

c. Deliver in person to Human Resources, 406 W Neely St. Atkinson, NE 68713

Submitted documents will be reviewed and WHMS will notify the requestor of the decision to grant the exemption (with or without conditions), deny the exemption, or request more information.

Requests for exemptions will be kept confidential and decisions will be shared only with those who need to know.

**Verification**

□ I request a medical exemption from the mandatory immunization listed above for medical reasons. I understand that my request for an exemption may not be granted if it is not reasonable or if it is determined that I will present a direct safety threat to myself or others that cannot be eliminated by other means. I verify that the information I submit in support of my request for a medical exemption from the mandatory immunization listed above is complete and accurate, and I understand that any intentional misrepresentation contained in this request may result in corrective action, up to and including termination of my employment.

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**Requestor’s Signature: Date:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Printed Name:**

**PART 2: HEALTHCARE PROVIDER SECTION**

This section must be completed by a Licensed Physician, Nurse Practitioner or Physician Assistant.

**MEDICAL OPINION - COVID- 19 IMMUNIZATION EXEMPTION**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** |  | **Date of Birth:** |  |

Please select the medically indicated contraindication below:

□ Temporary: Active COVID-19 infection.

\_\_\_\_\_\_\_\_\_\_\_ Date of positive test result

­­­­­­\_\_\_\_\_\_\_\_\_\_\_ Earliest Date Employee can receive the COVID -19 immunization

□ Temporary: Recently received COVID-19 monoclonal antibody therapy(mAB).

\_\_\_\_\_\_\_\_\_\_\_ Date of treatment

\_\_\_\_\_\_\_\_\_\_\_ Earliest Date Employee can receive the COVID-19 immunization

□ Severe allergy to the vaccine or vaccine component. Please describe in detail the previous allergic reaction and the contraindication to alternatives (if the allergy is to a component in all COVID-19 vaccines):

□ Other medical circumstances preventing vaccination with any available COVID-19 vaccine. Describe in detail:

It is my opinion that my patient referenced above has a contraindication to the COVID-19 vaccine as identified.

Signature of Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider’s Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Practice Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Practice Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REQUESTOR SECTION:**

I authorize my healthcare provider to release information to and, if necessary, speak with Occupational Health about my medical condition for the purpose of evaluation this exemption request.

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**Requestor’s Signature Date**

**MEDICAL EXEMPTION REQUEST PROVIDER INSTRUCTIONS**

Your patient is requesting a medical exemption from receiving CMS Mandated COVID-19 Immunization. Medical Exemptions may be granted for recognized contraindications.

The following **are not** considered contraindications to the COVID-19 vaccine specifically

* Local injection (erythema, induration, pruritus, pain, etc.) site reactions after (days to weeks) a previous COVID-19 vaccine
* Expected systemic vaccine side effects in previous COVID-19 vaccines (fever, chills, fatigue, headache, lymphadenopathy, vomiting, diarrhea, myalgia, arthralgia)
* Previous COVID-19 infection
* Vasovagal reaction after receiving a dose of any vaccination
* Being immunocompromised or receiving immunosuppressive medications
* Allergic reactions to anything not contained in the COVID-19 vaccines, including injectable therapies, food, pets, venom, environmental allergens, oral medication, latex etc. Please note the COVID-19 vaccines do not contain eggs or gelatin.
* Immunosuppressed person in the household
* Family member or household member who falls into a medical exempt category