**Advantage Health Care Staffing**

**Request for Medical Exemption from COVID-19 Vaccination Requirement**

***Employee/Student/Volunteer/Lessee Section: Complete the following information***

Name (Last, First): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\* Anyone receiving an exemption will be required to always follow facility policies. Facility may require you to always wear a N95 mask while in a facility AND complete mandatory weekly testing for COVID-19 possibly at your expense. \*\*

***Provider Section*: The Licensed Health Care Provider CURRENTLY TREATING YOU must complete and sign this section.**

**Provider Instructions**: By completing this form, you certify that different methods of vaccinating against COVID-19 have been considered, and the following medical contraindication precludes any/all vaccinations for COVID-19. Guidance for medical exemptions for COVID-19 vaccination can be obtained from the Advisory Committee on Immunization Practices (ACIP) available at <https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html>

***The following are NOT considered contraindications to COVID-19 vaccination:***

* Local injection site reactions after (days to weeks) previous COVID-19 vaccines (erythema, induration, pruritus, pain, etc.)
* Expected systemic vaccine side effects in previous COVID-19 vaccine doses or vaccinations (fever, chills, fatigue, headache, lymphadenopathy, vomiting, diarrhea, myalgia, arthralgia)
* Pregnancy, lactation, fertility
* Vasovagal reaction after receiving a dose of any vaccination
* Being an immunocompromised individual or receiving immunosuppressive medications
* Autoimmune conditions, including Guillain-Barre Syndrome
* Allergic reactions to anything not contained in the COVID-19 vaccines, including injectable therapies, food, pets, venom, environmental allergens, oral medication, latex. etc.
* Immunosuppressed person in the employee’s household
* Alpha-gal Syndrome
* History of Bell’s Palsy
* History of Dermal Filler use
* The COVID vaccines do not contain egg or gelatin, allergies to these substances are not a contraindication

**Please select the medically indicated contraindication below:**

CDC considers a history of the following to be a contraindication to vaccination with COVID-19 vaccines:

Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a component of the COVID-19 vaccine, including Polyethylene Glycol (PEG). Please describe the response in detail below and contraindication to alternatives such as the Johnson & Johnson vaccine, which does not include PEG.

Immediate allergic reaction of any severity to a previous dose or known (diagnosed) allergy to a component of the vaccine. Please describe the response in detail below and contraindication to alternatives.

Other medical circumstance preventing vaccination with any available COVID-19 vaccine. Be specific and describe in detail below:

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Signature of Health Care Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Practice Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**After you and your provider complete this form, submit it to Garilyn Grubbs in HR.** Information will be kept confidential. After review and acceptance of this information, your record will be updated to reflect this request.

***Name of facility*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Reviewed By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Request Accepted

 Request Denied