**Medical Exemption for COVID-19 Vaccinations Certification Form**

**Section 1 – Staff Completes**

The Centers for Medicare and Medicaid require all staff receive a primary series of COVID-19 vaccination. Medical exemptions are allowed; however, specific documentation must be maintained in the staff member’s file.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I am requesting a medical exemption from the **[Facility name]** mandatory vaccination policy for the COVID-19 Vaccine(s).

I verify that the information I am submitting to substantiate my request for exemption from the **[Facility name]** mandatory vaccination policy is true and accurate to the best of my knowledge. I understand that any falsified information can lead to disciplinary action, up to and including termination.

I further understand that the **[Facility name]** is not required to provide this exemption accommodation if doing so would pose a direct threat to myself or others in the workplace or would create an undue hardship for **[Facility name]**.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 2 – Practitioner Completes**

Dear Medical Provider,

**[Facility name]** requires vaccination against COVID-19 as a condition of employment because of the Conditions of Participation established by the Centers for Medicare and Medicaid. The employee named above is seeking an exemption to this policy due to medical contraindications. Please complete this form to assist **[Facility name]** in the reasonable accommodation process.

1. The staff member named above is a patient of mine? Yes No

2. The staff member named above has the following clinical contraindications (please list all):

3. Based on the clinical contraindications above, the staff named should be exempt from the following COVID-19 vaccines:

 Pfizer-BioNTech/Comirnaty Moderna Johnson & Johnson/Janssen

I attest that I am a Licensed Practitioner within the State of \_\_\_\_\_\_\_\_\_\_\_\_, and the State’s Scope of

Practice Laws allow me to complete this medical exemption form. I hereby recommend that

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ be exempt from the COVID-19 vaccination requirements. (Enter Staff Name)

Licensed Practitioner’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Credentials: \_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Provider Review:**

Medical Exemption Request \_\_\_\_\_\_ Approved \_\_\_\_\_\_\_ Denied

If medical exemption is denied describe undue hardship or reasons for denial:

Provider Representative Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_