Medical Exemption Request – Periodic Covid-19 Vaccine

This section to be completed by the individual requesting a medical exemption (Please complete all sections)

Name:_____ Contact Number: _____ Date of birth: _____

Home address: _____ Leader Name: _____

I am a(n): ☐ Employee ☐ Student ☐ Physician Partner

Employee ID Number or Worker ID #: _____ ☐ Full-time ☐ Part-time ☐ PRN

Department #: _____

I request a medical exemption from the periodic Covid-19 vaccination series. I understand that this form must be completed and returned by the deadline per policy. I also understand that if I am granted an exemption, I must always wear appropriate PPE when I am in direct contact with, or within 6 feet of, any patient or team member, or on-site at a Novant Health facility until otherwise directed by Novant Health leadership. If I am not granted an exemption, I must receive the vaccination as required by policy.

Individual's signature: _____ Date: _____

This section to be completed by the physician of the individual requesting a medical exemption

Dear Physician,

Covid-19 vaccination is the most effective method of controlling the spread of Covid-19, and the Advisory Committee on Immunization Practices (ACIP) strongly recommends that all healthcare workers receive the vaccine. In keeping with our commitment to patient safety and *First Do No Harm*, Novant Health now requires its employees, physicians, allied health professionals, students, contractors, vendors, and volunteers to receive a Covid-19 vaccination series.

Sincerely yours,

David H. Priest, MD, MPH, FIDSA
Senior Vice President, Chief Safety, Quality, and Epidemiology Officer
Novant Health

Physician Certification of Contraindication

I certify that my patient, _____ (patient name) should not be vaccinated against Covid-19 because he/she has one of the following recognized contraindications:

☐ **I am requesting a permanent exemption from the Covid-19 vaccine** *(If so, indicate reason below):*

☐ **Documented anaphylactic allergic reaction or other severe adverse effect to a previously administered Covid-19 vaccine or other severe reaction such as, TTS –** e.g., cardiovascular changes, respiratory/distress, or history of treatment with epinephrine or other emergency medical attention to control symptoms. Generally, does <u>not</u> include gastro-intestinal symptoms as the sole presentation of allergy.

Describe the specific reaction: _____
_____
_____

☐ **Documented anaphylactic allergic reaction to a component of the vaccine –** does not include allergic reaction to egg (vaccines are egg free), sore arm, local reaction, or subsequent respiratory tract infection.

Describe the specific reaction: _____
_____
_____

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☐ **I am requesting a temporary exemption from the Covid-19 vaccine** *(If so, indicate reason below):*

Describe why the temporary exemption is being requested (pregnancy, or severe self-limited illness, etc.):

_____
_____
_____
_____
_____

*Please provide the date of expiration for the temporary exemption request:*_____

Physician signature (required): _____ Date: _____

Provider license number (required): _____

Physician printed name: _____ Phone #: _____

Send completed form to the Medical Exemption mailbox – medicalbasedvaccinerequest@novanthealth.org