NEW HIRE

REQUEST FOR MEDICAL COVID-19 VACCINE EXEMPTION

Send Completed Form to exemption@nmhs.org or fax to 402-354-2218. Please type *encrypt* in the subject line.

EMPLOYEE COMPLETE:

Name:_____ Supervisor Name: _____

Preferred Email: _____ Recruiter: _____

If I am granted an exemption, I certify the above information to be true and accurate, and understand and agree to abide by all Methodist protocol for unvaccinated staff.

Employee Signature: _____

PROVIDER COMPLETE:

CMS regulations require COVID-19 vaccination for all staff without sincerely held religious objections or medical contraindications. Your patient (listed above) is requesting a medical exemption from receiving the COVID-19 vaccine based on a recognized medical condition for which vaccines are contraindicated, as a reasonable accommodation under the Americans with Disabilities Act (ADA). Guidance for medical contraindications for COVID-19 vaccination can be obtained from the Advisory Committee on Immunization Practices (ACIP) available at: https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html.

Please note, the following are **not** considered contraindications to COVID-19 vaccination:

- Local injection site reactions after (days to weeks) previous COVID-19 vaccines
- Expected systemic vaccine side effects in previous COVID-19 vaccines
- Previous COVID-19 infection
- 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. Please note that the COVID-19 vaccines do not contain eggs or gelatin.
- Immunosuppressed person in the healthcare worker's household
- Alpha-gal Syndrome
- Family member or household member who falls into a medically exempt category

(REQUIRED – Please include as much detail as possible)
It is my opinion that my patient referenced above has the following contraindication to COVID-19 vaccination:

_____

_____

_____

_____

_____

☐ Temporary deferral from COVID-19 vaccination due to recent receipt of COVID-19 monoclonal antibodies or convalescent plasma, a recent COVID-19 diagnosis or recent multisystem inflammatory syndrome in adults (MIS-A).

Date eligible to receive COVID-19 vaccination: _____

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

Printed Physician Name and Address

Physician Signature Date

MEDICAL EXEMPTION PANEL COMPLETE:

- ☐ Accepted Medical Exemption
- ☐ Denied Medical Exemption

If the request was rejected, please indicate why below:

Printed Reviewer Name

Reviewer Signature Date

HR USE ONLY:

- ☐ Communicated to Employee & Supervisor: _____
- ☐ Data Entered: _____
- ☐ Copy sent to Employee Health: _____