MEDICAL EXEMPTION REQUEST FORM

This form is intended to assist North Central Health Care in assessing a request for an exemption and/or accommodation from being vaccinated against COVID-19 based on an employee's medical needs.

Employee's Name: _____ Date of Request: _____

Telephone Number: _____ Employee's Position: _____

Program Location: _____ Employee ID: _____

Completed by Licensed Healthcare Provider:

Please certify below the medical reason that your patient should not be immunized for COVID-19 by completing this form and attaching available supporting documentation, as appropriate. Please include all information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications.

_____

_____

_____

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_____

Healthcare Provider's Statement of Exemption/Accommodation

I certify that the above-named individual is a patient of mine and should be considered exempt from receiving the COVID-19 vaccine due to a medical contraindication or deferred from receiving the COVID-19 vaccine due to a temporary medical condition. *Medical contraindication as identified by the Centers for Disease Control and Prevention (CDC) can be found at https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html

Physician signature (required): _____Date_____

Physician printed name: _____

Provider license number (required): _____

Phone #: _____

I am requesting a medical exemption from receiving the COVID-19 vaccine at this time. I have read and fully understand the information on this request for exemption and understand that my request requires the attestation by a medical professional familiar with my condition to support my request. I also understand that if my request is approved, it is approved for the period indicated or until such time as regulatory requirements related to vaccination of individuals in the health care setting are amended, and that exemption for COVID-19 vaccination for any future periods will require the completion and submission of a new request form and may require the provision of additional information and/or supportive documentation. I certify that the information in this request is complete, true, and accurate to the best of my knowledge. I authorize my licensed health care provider to provide North Central Health Care with medical information about my medical exemption for the COVID-19 vaccination. I understand that providing false, misleading information or intentional misrepresentation is grounds for discipline, up to and including termination from employment.

Print Employee Name _____

Employee Signature _____ Date _____

1. Return this form to North Central Health Care Human Resources, preferred method is an email to NCHCVaccineExemptions@norcen.org
2. This request will be reviewed by designated individuals. A request does not imply an approval of exemption.
3. Additional information and/or supporting documentation may be requested. Failure to timely provide such information and/or documentation may result in a denial of the request for exemption.
4. Individual will be notified of the decision regarding the requested exemption.
5. If a medical exemption is granted, the individual may be required to wear a surgical mask, use other personal protective equipment and/or take other infection control precautions whenever the individual is in any designated NCHC facility.

Accommodation Decision-HR Use Only

Date Request Received: _____

Interactive Discussion Date(s) if applicable: _____

Accommodations:

□ approved as requested

□ approved but different from the original request

□ denied

Identify the accommodation provided.

If Accommodation is granted, list required alternative safety precautions required:

_____

_____

_____

If the approved accommodation is different from the one originally requested, explain the basis for denying the original request.

If an alternative accommodation was offered, indicate whether it was:

□ accepted

□ rejected

If it was rejected, state the basis for rejection.

_____

_____

_____

If the accommodation is denied and no alternative accommodation was proposed, explain the basis for denying the request without an alternative accommodation.

_____

_____

_____

Name of Representative: _____

Signature of Representative: _____

Date: _____