**Request for Medical Exemption**

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

Employee Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Department: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Job Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Employment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Explain in your own words why you are requesting this exemption.

Provide the attached correspondence to your medical provider and return with your exemption request.

I hereby affirm the truthfulness of this statement.

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

*To be completed by Review Panel:*

\_\_\_\_\_\_ Exemption Approved \_\_\_\_\_\_ Exemption Declined

Acknowledgement of Review Panel’s decision:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, Vice President of Human Resources

Dear Medical Provider,

Colquitt Regional Medical Center requires vaccination against COVID-19as a condition of employment and as required by recent federal mandate regulations.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Staff member name) is seeking an exemption to this policy due to medical contraindications. Medical contraindications and precautions for immunization should be based on the most recent recommendations of the Advisory Committee on Immunization Practices/CDC.

Please complete this form to assist Colquitt Regional Medical Center in the reasonable accommodation process.

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| **It is my medical opinion that the person named above should not receive the  *COVID-19 vaccination* due to:**  \_\_\_ Severe allergic reaction (e.g. anaphylaxis) after a previous dose or close to a vaccine component. Please provide the dates of allergy testing and the results of such testing:  \_\_\_ Other (explain, attach additional sheets as necessary): |
| **This exemption should be:**  \_\_\_Temporary, expiring on: \_\_/\_\_/\_\_\_\_, or when \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_Permanent |

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

|  |  |
| --- | --- |
| Medical Provider Name (print): | |
| Medical Provider Signature: | Date: |
| Practice Name & Address: | Provider Phone: |