Medical Exemption / Waiver / Opt-Out Request

COVID-19 Vaccination 2022/2023 – rev.10.12.22

IMPORTANT: exemption requests are required to be submitted and approved as determined by Trinity Health.

Instructions for Completing Medical Exemption / Waiver / Opt-Out Request

Colleague / Candidate

- ☐ Complete all required fields in the colleague / candidate information section.
- ☐ Have your treating healthcare provider complete and sign the medical certification section. Of note, your healthcare providers signature is not an approval of a medical exemption, it is an attestation of the accuracy of the information provided.
- ☐ If your primary work location is **Florida**, you may designate a waiver / opt-out by completing the Colleague / Candidate Certification section on page 4.
- ☐ Sign and date this form. All pages must be submitted.

Treating Health Care Provider

- ☐ Complete all required fields in the health care provider section. Note: provider specialty is a required field. Please reference the authorized licensed health care provider section below to verify that you are an authorized health care provider.
- ☐ Complete the treating health care provider section below, sign and date this form. By signing this form, you are not approving a medical exemption, you only are attesting to the accuracy of information provided and the fact that you are recommending your patient not receive the COVID-19 vaccine as indicated.
- ☐ Return completed form to the colleague / candidate identified below.

Colleague / Candidate Information

Name:

Colleague ID:
(Current Colleagues Only)

Health Ministry:

Date:

Recruiter:
(Candidates Only)

Treating Health Care Provider Information

Printed Name:

Medical License Number:

Provider Specialty:

Phone Number:

Address:

Instructions for Completing Medical Exemption Request

State	Authorized Licensed Health Care Provider
Florida	Treating physician (M.D or D.O), physician assistant, or advanced practice registered nurse
New York	Treating physician (M.D. or D.O) or treating nurse practitioner
All Others	Treating physician (M.D. or D.O), or treating advanced practice professional (nurse practitioner, physician assistant, or clinical nurse specialist)

Note: Health Care Providers cannot sign their own exemption / certification request.

Licensed Healthcare Provider: please mark the contraindications / precautions or other medical condition / disability that apply to this patient and sign and date this form. Conditions noted as a contraindication must be consistent with current guidelines published by the CDC. By signing this form, you are not approving a medical exemption, you are only attesting to the accuracy of information provided and the fact that you are recommending your patient not receive the COVID-19 vaccine as indicated.

Vaccine Contraindication Certification (mark all that apply) Note that contraindication to one vaccine type does not preclude receipt of another vaccine type	
Adenovirus vector vaccine; Janssen (Johnson and Johnson)	☐ History of a severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a component of the Janssen COVID-19 vaccine ☐ History of a known diagnosed allergy to a component of the Janssen COVID-19 vaccine Note: People with a known allergy to polysorbate have a contraindication to Janssen COVID-19 vaccine and a precaution to mRNA COVID-19 vaccines. In all other cases, an allergy-related contraindication to one type of COVID-19 vaccine is a precaution to the other types. ☐ History of thrombosis with thrombocytopenia syndrome (TTS) following the Janssen COVID-19 Vaccine or any other adenovirus-vectored COVID-19 vaccine ☐ Other_____ (must provide specifics)
mRNA vaccine; Pfizer (COMIRNATY) or Moderna (SPIKEVAX)	☐ History of a severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a component of COMIRNATY or SPIKEVAX COVID-19 vaccine ☐ History of a known diagnosed allergy to a component of COMIRNATY or SPIKEVAX COVID-19 vaccine ☐ History of myocarditis or pericarditis after a dose of an mRNA COVID-19 vaccine ☐ Other_____ (must provide specifics)
Protein subunit vaccine; Novavax	☐ History of a severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a component of the COVID-19 vaccine ☐ History of a known diagnosed allergy to a component of the Novavax vaccine Note: People with a known allergy to polysorbate have a contraindication to Novavax COVID-19 vaccine and a precaution to mRNA COVID-19 vaccines. In all other cases, an allergy-related contraindication to one type of COVID-19 vaccine is a precaution to the other types. ☐ History of myocarditis or pericarditis after a dose of Novavax COVID-19 vaccine

- An immediate allergic reaction to a vaccine or injectable therapy is defined as any hypersensitivity-related signs or symptoms such as urticaria (hives), angioedema (visible swelling), respiratory distress (e.g., wheezing, stridor), or anaphylaxis that occurs within four hours following administration.
- Severe allergic reactions include:
    - Possible anaphylaxis, a progressive life-threatening reaction that typically includes urticaria but also with other symptoms such as wheezing, difficulty breathing, or low blood pressure
    - Any angioedema affecting the airway (i.e., tongue, uvula, or larynx)
    - Diffuse rash which also involves mucosal surfaces (e.g., Stevens-Johnson Syndrome)

If you marked Other above, is the contraindication a result of disability (i.e., an impairment that substantially limits a major life activity)?

- ☐ Yes
- ☐ No

If you noted allergic reaction above, please complete the following:

Specific component(s) of the vaccine the patient is allergic to, if known:_____

Please describe the reaction: _____

How long after receiving the vaccine did symptoms start: _____

How long did symptoms last: _____

Was treatment required?

- ☐ Yes, please provide specifics _____
- ☐ No

Deferral Certification	
General (request for deferral)	May apply for deferral for the following: ☐ Acute COVID-19 infection documented in the past 90 days. The person is eligible for vaccination at 3 months from symptom onset or positive test * Date of positive test result: _____
* Deferral for 90-days post onset of acute infection / date of receipt of COVID-specific treatments as outlined.	

When did you start treating the patient identified above for this condition? _____

Is the medical condition

- ☐ Permanent
- ☐ Temporary, and if temporary, expected duration _____

Colleagues / Candidates with a primary work location in **Florida** only

- ☐ Currently pregnant
- ☐ Planning pregnancy

Healthcare Provider Certification

Florida Healthcare Provider

I certify that I have a healthcare provider-patient relationship with the colleague identified above and that it is my professional opinion as a physician or physician assistant who holds a valid, active license under chapter 458 or chapter 459, Florida Statutes, or an advanced practice registered nurse who holds a valid, active license under chapter 464, Florida Statutes, that COVID-19 vaccination is not in the best medical interest of the colleague.

Florida Health Care Provider Signature**:** _____ Date**:** _____

New York Healthcare Provider

I certify that I have a healthcare provider-patient relationship with the colleague identified above and that immunization with the COVID-19 vaccine is detrimental to the health of the colleague based on the pre-existing conditions checked or listed above.

New York Health Care Provider Signature: _____ Date**:** _____

Healthcare Providers in **all other states**

I certify that I have a healthcare provider-patient relationship with the colleague identified above and that the above statements are true and accurate.

Health Care Provider Signature**:** _____ Date**:** _____

Colleagues / Candidates with a primary work location in **Florida** only

If you are requesting a medical opt-out, please provide a statement that receiving the vaccine is injurious to your health and well-being or is injurious to the health and well-being of another individual who resides with you. If your primary work location is not in Florida, this section is not applicable to you.

Please mark the reason you are requesting to opt-out of the COVID-19 vaccine requirement	
Opt-out based on COVID-19 immunity	By signing this form, I hereby declare that, to the best of my knowledge, the laboratory documentation I am providing with this opt-out statement is sufficient laboratory criteria for proof of COVID-19 immunity. Please mark which of the following FDA Emergency Use Authorization of FDA Approved COVID-19 Test PCR Antigen Antibody Date of test _____
Opt-out based on periodic testing	By signing this form, I agree to comply with regular periodic diagnostic testing for COVID-19, to occur not more than weekly, or upon evidence of COVID-19 symptoms, with an FSA Emergency Use Authorization or FDA Approved diagnostic COVID-19 test, at no cost to me.
Opt-out based on employer-provided personal protective equipment	By signing this form, I hereby declare that I agree to comply with my employer's reasonable written requirement to use employer-provided personal protective equipment when in the presence of other employees or other persons.

Colleagues / Candidates with a primary work location in **Iowa** only

If your primary work location is **Iowa**, you may indicate your request for a medical waiver to the COVID-19 vaccination requirement by marking the statement below.

☐ By signing this form, I declare that receiving the COVID-19 vaccine is injurious to my health and well-being or is injurious to the health and well-being of another individual who resides in my household.

Colleague / Candidate Certification

Approved requests may be revised or revoked at any time in order to comply with state law, federal law, and/or employer policy. By signing or typing my name, I attest that the information above is true and accurate.

Signature: Date: