Medical Exemption Request

Influenza Vaccination 2021

Trinity Health

IMPORTANT: at a minimum, exemption requests are required to be submitted and approved annually.

Colleague Information

Name: Colleague ID:

Health Ministry: Date:

Treating Health Care Provider Information

Printed Name: Provider Specialty:

Address: Phone Number:

Instructions for Completing Medical Exemption Request

Colleague

- Complete all required fields in the colleague information section above.
- Have your treating healthcare provider complete and sign the medical certification section below. 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.
- Sign and date this form.
- Upload your completed form to the HR4U colleague portal no later than Oct. 22, 2021. Both pages must be submitted.

IMPORTANT: Please retain your HR4U case number for your records. Note, if you do not see a case number in your HR4U portal, your submission is not complete.

Treating Health Care Provider

- Complete all required fields in the health care provider section above. 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.
- Return completed form to the colleague identified above.

State	Authorized Licensed Health Care Provider
All States	Treating physician (M.D. or D.O) or treating advanced practice professional (nurse practitioner or physician assistant)

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

Instructions for Completing Medical Exemption 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. By signing this form, you are not approving a medical exemption, you are only attesting to the accuracy of information provided.

Inactivated Influenza Vaccine (list all that apply)	
Contraindication Conditions in a recipient that may increase the risk for a serious adverse reaction – vaccine should not be administered in these circumstances	☐ **History of severe allergic reaction** (e.g., anaphylaxis) to **any component** of the vaccine. Please specify the component _____ _____ ☐ **History of severe allergic reaction** (e.g., anaphylaxis) to a **previous dose** of any influenza vaccine. Please provide date of last dose of influenza vaccine that resulted in severe allergic reaction _____
Precaution Conditions in a recipient that might increase the risk for a serious adverse reaction, might cause diagnostic confusion, or might compromise the ability of the vaccine to produce immunity – vaccine can be administered if benefit of vaccine outweighs risk of possible reaction	☐ **History of Guillain-Barré syndrome (GBS)** occurring within 6 weeks of receipt of a prior influenza vaccine. Please specify date of last dose of influenza vaccine that resulted in Guillain-Barré syndrome occurring within 6 weeks _____ The decision to give vaccine should be based on careful consideration of potential benefits and risks – check one of the following: ____Benefit of vaccine outweighs risk – support receipt of vaccine ____Benefit does not outweigh risk – do NOT support vaccination
Other Must provide specifics	

IMPORTANT: colleagues with an egg allergy must receive recombinant egg-free vaccine and are not exempted from the influenza vaccination requirement.

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

Health Care Provider Certification

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

Health Care Provider Signature: _____ Date: _____

Colleague 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 my name, I attest that the information above is true and accurate.

Colleague Signature: _____ Date: _____

Trinity Health