COVID-19 Vaccine Medical Exemption Request

Employee Form

PRINT LEGAL NAME (as in Workday System)	**Date of Birth**
Employee ID Number:	**Contact Number:**
Job Title:	**Department:**
I certify I am one of the following: ❑ Employee ❑ Physician ❑ Volunteer ❑ Non-Employed Labor ❑ Student	
I certify I am one of the following: ❑ 100% Permanent Remote ❑ Hybrid ❑ On-Site	

Any Employee/Physician/Volunteer/Other requesting a medical exemption to the mandatory vaccination requirement must complete the following documentation in accordance with the applicable policy on Workforce COVID-19 vaccinations.

I have been offered the COVID-19 vaccine by Ochsner Health. I understand that because I work in a health care environment, I may place others at risk, including patients and co-workers, if I work while infected. To minimize this risk, I understand that if my request is approved, I will always be required to wear an N-95 mask for direct patient care and KN-95 mask for non-direct patient care and adhere to the weekly testing protocol.

Please answer the following questions:

1. **When was the last date you received the flu vaccine? (If you are unsure, you can find in ReadySet)**

2. **When was the last date you received ANY vaccine? (If you are unsure, you can find in ReadySet)**

3. **If you have been vaccinated before, what has changed?**

4. **Have you had a previous anaphylaxis reaction to the COVID vaccine?**

Verification

I request an exemption from the COVID-19 vaccine requirement for medical reasons. I understand that my request for an exemption may not be granted if it is not reasonable or if it is determined that I will present a direct safety threat to myself or others that cannot be eliminated by other means. I verify that the information I submit in support of my request for a medical exemption from the COVID-19 vaccine is complete and accurate, and I understand that any intentional misrepresentation contained in this request may result in progressive discipline, up to and including termination of my employment.

****Exemption Request will be reviewed for approval and you will be notified of that decision****

Employee Signature:	**Date:**

INSTRUCTIONS

1. Complete and sign the **Employee Form.**
2. Present the **Healthcare Provider Verification Form** to your treating healthcare provider to complete.
3. Please send both completed forms to your Recruiting Representative
4. **Ochsner Rep**: Please email both completed forms into CovidExemptionRequests@ochsner.org

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Healthcare Provider Verification Form

Employee Section:

Name:_____ **Employee ID Number:**_____

Email completed Form 1 of 2 and Form 2 of 2 to CovidExemptionRequests@ochsner.org. Requests for exemption will be kept confidential and shared only with those who need to know.

I authorize my treating healthcare provider to release information to and, if necessary, speak with Ochsner Health about my medical condition for the sole purpose of evaluating this exemption request.

Signature: _____

Treating Healthcare Provider Section: Must be completed by a TREATING health care Provider who has the expertise to give an opinion about the employee's medical condition and the limitations imposed by it. Forms completed by employee will not be accepted.

Provider Instructions: Your patient's employer's COVID-19 vaccination policy requires staff to receive the COVID-19 vaccine. Your patient is requesting a medical exemption from receiving the COVID-19 vaccine. Medical exemptions may be granted for recognized contraindications.

The following are not considered contraindications to COVID-19 vaccination:

- Local injection site reactions after (days to weeks) previous COVID-19 vaccines (erythema, induration, pruritus, pain, etc.)
- Expected systemic vaccine side effects in previous COVID- 19 vaccines (fever, chills, fatigue, headache, lymphadenopathy, vomiting, diarrhea, myalgia, arthralgia)
- 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 the COVID vaccines do not contain egg or gelatin.
- Immunosuppressed person in the healthcare worker's household
- Family member or household member who falls into a medically exempt category

Please select medically indicated contraindication below:

❑ Temporary: Active COVID-19 infection Date of positive test result: _____

❑ Temporary: Recently received a COVID-19 monoclonal antibody therapy (mAb).

Date of therapy: _____

❑ Temporary health condition that contraindicates receiving COVID-19 vaccine. Temporary health condition is (describe)_____, which will make my patient eligible for the COVID-19 vaccination on (date)_____.

❑ Severe allergy to the vaccine or vaccine component. Please describe in detail the previous allergic reaction and the contraindication to alternatives (if the patient is allergic to a component of a COVID-19 vaccine):

_____
_____
_____

❑ Other medical circumstance preventing vaccination with any available COVID-19 vaccine. Describe in detail:

_____
_____
_____
_____

Please list the specific COVID-19 vaccines that are contraindicated: _____

_____
_____

It is my opinion that my patient referenced above has the COVID-19 vaccine contraindication as identified.

Signature of Provider:_____ **Date**:_____

Printed name:_____ **Practice name**:_____

Practice telephone number: _____ **Practice email:** _____