Printed Name: Colleague ID:

Date:

Important: exemption requests are required to be submitted and approved annually

Health Care Provider Information

Printed Name: Provider Specialty:

Address: Phone Number:

Licensed Healthcare Provider: please mark the contraindications / precautions or other medical condition / disability that apply to this patient and sign and date this form. Licensed Healthcare Provider must include either a 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.

Vaccine Contraindication Certification (list all that apply) – requires health care provider signature Note that contraindication to one vaccine type does not preclude receipt of another vaccine type	
Johnson and Johnson	☐ Known history of severe allergic reaction (anaphylaxis) to any component of the vaccine or immediate allergic reaction ☐ Previous history of heparin-induced thrombocytopenia (HIT) ☐ Contraindication to mRNA vaccines (must specify below) AND female under the age of 50 ☐ Other_____ (must provide specifics)
mRNA Pfizer or Moderna	☐ Known history of severe allergic reaction (anaphylaxis) to any component of the vaccine or immediate allergic reaction ☐ Known history of severe allergic reaction (anaphylaxis) to the first dose of either mRNA vaccine ☐ Previous history of Multisystem Inflammatory Syndrome (MIS) of adults or children ☐ Documented Myocarditis after first dose of mRNA vaccine ☐ Other_____ (must provide specifics)

Deferral Certification – requires health care provider signature	
General (request for deferral)	May apply for deferral for the following: ☐ Acute COVID-19 infection documented in the past 90 days* ☐ Receipt of monoclonal/polyclonal COVID-19 antibody treatment within the past 90 days* ☐ Receipt of high titer COVID-19 convalescent plasma within the past 90 days* ☐ Currently pregnant**
* Deferral for 90-days post onset of acute infection / date of receipt of COVID-specific treatments as outlined. ** Will be required to complete one of the following prior to returning to work: • Single dose vaccines – must be 14-day post vaccination before returning to work. • Two dose vaccines – must complete second dose before returning to work.	

I attest 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:** _____2021

Deferral Certification – only requires colleague attestation and signature
☐ I attest that I am actively trying to become pregnant and I am not aware of any reason I cannot become pregnant.

By typing or signing my name, I attest that my statement above is true and accurate, that I am actively trying to become pregnant and I am not aware of any reason I cannot become pregnant.

Name: