Letter head

Date

Address
Address

RE: Update to Vaccine Requirements – COVID-19 Vaccine Now Required

Dear [Insert Name from Notice Provision]:

As you may be aware Trinity Health made the decision to require the COVID-19 Vaccine for its employees and for any students who plan to enter a Trinity Health facility as part of an educational experience. This requirement aligns with our Core Value of Safety which means Trinity Health will do what we are able to protect people. The safety of our patients and colleagues is very important and as such the following guidance is provided to assist with implementing procedures to ensure students who rotate through our premises are compliant with our policy requiring COVID-19 vaccination.

Similar to the flu vaccine, Trinity Health will permit students with an approved exemption to participate in educational offerings on our premises. These exemptions include both religious and medical exemptions. Just as with the flu vaccine exemption process we expect you, as the educational institution, to review and approve or deny those exemption requests for your students. In addition to these two categories of exemption we are also permitting a deferral for those women who are, or are attempting to become, pregnant. This deferral applies only to women and is not due to fertility concerns but is offered because women may be pregnant and not realize it for many weeks. This deferral is offered until the results of a study being conducted by the CDC on the vaccine and early pregnancy are published. It will be evaluated for continuation when those results are known.

In order to assist you with this process we are attaching the contents of the medical exemption document we are using for reference. Please consult with your legal counsel as to the form, process and standard you need to utilize for any exemption or deferral request.

Please let me know if you have any questions.

Sincerely,

Signature block

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:

Name: Colleague ID:

Date:

A religious exemption to COVID-19 immunization may be granted based on an individual's sincerely held religious belief, practice or observance that prohibits COVID-19 vaccination (see Trinity Health's COVID-19 Prevention Policy). In this analysis, "religious belief, practice, or observance" includes moral or ethical beliefs as to what is right and wrong which are sincerely held with the strength of traditional religious views. Social, political, or economic philosophies, as well as personal preferences, do not constitute sincerely held religious beliefs.

In the space provided below, please provide a statement describing your sincerely held religious belief, practice, or observance and how the COVID-19 vaccination will violate this belief. Your statement should explain your religious belief, establish that it is sincerely held, and explain in what ways receiving the COVID-19 vaccination conflicts with your religious belief. You may attach any documents that support your statement.

Important: exemption requests are required to be approved annually.

Statement

By signing my name, I attest that my statement above is true and accurate and that I hold a sincere religious belief that prohibits COVID-19 vaccination.

Name: