

Request for Medical Exemption from COVID-19 Vaccination Form

Name: _____

Department: _____

An emergency regulation was issued pursuant to the authority vested in the New York State Public Health and Health Planning Council and the New York State Commissioner of Health by Public Health Law Sections 225, 2800, 2803, 3612, and 4010, as well as Social Services Law Sections 461 and 461-e, Title 10 (Health) of the Official Compilation of Codes, Rules and Regulations of the State of New York which mandates employees in nursing homes to be vaccinated with a COVID-19 vaccine prior to September 27, 2021, and mandates employees in the local health departments to obtain a COVID-19 vaccine prior to October 7, 2021.

A medical exemption may be granted upon receipt of a completed form (below) not more than 6 months old, signed and certified by a licensed healthcare provider, who is not related to the submitter, and whose specialty is appropriate to the associated condition.

Medical exemptions expire when the medical condition(s) contraindicating COVID-19 vaccination changes in a manner which permits vaccination. PHRC, as noted below, at its discretion, can require periodic updates and resubmittal of medical exemption documents in order to continue to support the contraindication. The assigned expiration is at the sole determination of PHRC. Individuals with an approved exemption will be required to comply with COVID-19 testing and other preventive requirements as specified in the exemption approval and as may be updated by later notification.

After your request has been reviewed and processed, you will be notified if an exemption has been granted. If the approved exemption contains an expiration, you will be expected to complete the requirement at that time. Should the condition continue, or a new vaccination contraindication occurs, or the current exemption expires, a new request with updated documentation is required. Individuals are permitted to reapply if new documentation and information should become available.

In order to submit a request, please:

- Read the Center for Disease Control and Prevention (CDC) and Occupational Safety and Health Administration (OSHA) COVID-19 Vaccine Information;
- Complete the following page of this form;
- Have your Licensed Health Care Provider complete the provider section of this form;
- Submit the completed documents
- Note: Incomplete submissions will not be reviewed.

Be sure all forms and documentation are submitted at one time. Initial next to each of the statements below:

_____ I request exemption from the COVID-19 vaccination requirements due to my current medical condition.

_____ I understand and assume the risks of non-vaccination.

_____ I accept full responsibility for my health, thus removing liability from PHRC since I will not be vaccinated.

_____ I understand that as I am not vaccinated, in order to protect my own health, the health of my patients and their families, my co-workers and the health of the community, I will comply with additional COVID-19 testing requirements and other preventive guidance.

_____ I understand that should I develop symptoms of, have an exposure to, or contract COVID-19, I am required to immediately report it to my Supervisor and comply with all isolation and quarantine procedures specified by the Cattaraugus County Health Department.

_____ I acknowledge that I have read the CDC and OSHA COVID-19 Vaccine Information.

_____ I understand that this exemption will expire when the medical condition(s) contraindicating vaccination changes in a manner which permits vaccination.

_____ I understand and agree to comply with and abide by all PHRC COVID-19 policies and procedures.

_____ I understand that this exemption is only valid for the approved period and I may need to submit a new request for any subsequent changes, new medical contraindications, or on expiration of an approved exemption.

_____ I authorize my licensed health care provider to provide PHRC and New York State Department of Health with medical information about my medical exemption for the COVID-19 vaccination.

_____ I certify that the information I have provided on and in connection with this request is accurate and complete as of the date of this submission.

_____ I understand this exemption may be revoked and I may be subject to disciplinary action if any false information has been used to request an exemption.

_____ I understand that, if approved, this exemption is provisional based on the current New York State Department of Health Order for COVID-19 vaccination and is subject to change.

Printed Name: _____

Signature: _____

Date: _____

Request for Medical Exemption from COVID-19 Vaccine Health Care Provider Form

Attention Health Care Provider: An emergency regulation was issued pursuant to the authority vested in the New York State Public Health and Health Planning Council and the New York State Commissioner of Health by Public Health Law Sections 225, 2800, 2803, 3612, and 4010, as well as Social Services Law Sections 461 and 461-e, Title 10 (Health) of the Official Compilation of Codes, Rules and Regulations of the State of New York which mandates employees in nursing homes to be vaccinated with a COVID-19 vaccine prior to September 27, 2021, and mandates employees in the local health departments to obtain a COVID-19 vaccine prior to October 7, 2021.

_____ (insert patient's name) is requesting a medical exemption from this vaccination requirement. A medical exemption may be allowed for certain recognized contraindications.

Please certify below the medical reason that your patient should not be immunized for COVID-19 by completing this form and attaching available supporting documentation.

Option 1 - Allergy

_____ A documented history of a severe allergic reaction to any component of a COVID-19 vaccine or to a substance that is cross-reactive with a component. Please indicate which of the following vaccines are contraindicated and name the components, by vaccine NOTE: since egg free vaccine is available, history of egg allergy will not be accepted as a routine medical exemption.

Moderna - List the component(s): _____

Pfizer - List the component(s): _____

Johnson&Johnson - List the component(s): _____

_____ A documented history of a severe allergic reaction after a previous dose of the COVID-19 vaccine Please indicate to which vaccine the patient had a reaction and the date of the vaccine & reaction.

Moderna - Date of Vaccine & Reaction: _____

Pfizer - Date of Vaccine & Reaction: _____

Johnson&Johnson - Date of Vaccine & Reaction: _____

Option 2 – Physical Condition/Medical Circumstance

_____ The physical condition of the patient or medical circumstances relating to the individual are such that immunization is not considered safe. Please state, with sufficient detail for independent medical review, the specific nature and probable duration of the medical condition or circumstances that contraindicate immunization with the COVID-19 vaccine.

Explanation:

Option 3 - Other

_____ Other. Please provide this information in a separate narrative that describes, in detail, the medical condition or disability in detail that you opine would exempt this individual from vaccination:

Explanation:

Certification I certify that _____ (patient name) has the above contraindication and support the request for a medical exemption from the COVID-19 vaccine requirement.

Provider Name: _____

Medical Provider Specialty: _____

Signature: _____

Provider License Number: _____

Date: _____

Name of Provider Company: _____

Address: _____

Phone Number: _____