Southeast HEALTH

Request for Medical Exemption

Name _____ Date _____

If you are an ACOM student please indicate your year: ___ OMS I ___ OMS II ___ OMS III ___ OMS IV ___ Fellow

Email _____ Department / Division _____

Phone Number _____ Employee / Student Number _____ Job Title *(does not apply if you are an ACOM student)* _____

Explain in your own words why you are requesting this exemption.

Provide the attached correspondence to your medical provider and return with your exemption request.

I hereby affirm the truthfulness of this statement.

SIGN HERE _____ Signature _____ Date

Southeast HEALTH

Request for Medical Exemption

Dear Medical Provider,

Southeast Health requires vaccination for certain individuals against COVID-19 as required by recent regulations. The individual named here is seeking an exemption to this policy due to medical contraindications. Medical contraindications and precautions for immunization should be based on the most recent recommendations of the Advisory Committee on Immunization Practices/CDC.

Please complete this form to assist Southeast Health in the reasonable accommodation process.

It is my medical opinion that _____ **should not receive**
(patient name)

the _____ **due to:**
(insert any and all specific COVID-19 vaccinations by name)

_____ Severe allergic reaction (e.g. anaphylaxis) after a previous dose or close to a vaccine component. Please provide the dates of allergy testing and the results of such testing:

_____ Other (explain, attach additional sheets as necessary):

This exemption should be:

☐ Temporary, expiring on: _____ or when _____

☐ Permanent

I certify the above information to be true and accurate, and request exemption from the COVID-19 vaccination for the above-named individual.

_____
Medical Provider Name (print)

SIGN HERE _____ _____
Medical Provider Signature Date

_____ _____
Practice Name Provider Phone

_____
Practice Address, City, State, & Zip