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Form Version: 12-9-2021

Request for Medical Exemption from COVID-19 Vaccine Form

Name: _____ Badge # (if applicable): _____

Campus: _____ Department: _____

Relationship to Kettering Health (Circle One): Employee | Med Staff | Student Contractor | Volunteer

Other or New Hire: _____
If a new hire, please provide your date of hire.

Email: _____
Note, all decisions will be communicated to your assigned Kettering Health email, if available.

Phone (so we can contact you with questions): _____

Kettering Health employees, employed and non-employed medical staff, volunteers, contractors, vendors, and students are required to be vaccinated against COVID-19 unless they are granted a medical or religious exemption. Only evidence-based medical contraindications against the COVID-19 vaccination that have been confirmed by a licensed healthcare provider will be accepted. A medical exemption may be granted if the individual completes this form in its entirety and provides the required documentation to support the medical exemption request.

All requests will be carefully reviewed to determine if the request should be granted. You will be notified if an exemption has been granted or denied.

Medical exemption process:

- Read CDC Covid-19 Vaccine Information Talking to Recipients about COVID-19 Vaccination | CDC (refer to section Understanding and Explaining COVID-19)
- Complete and sign the statements below
- Have your Licensed Health Care Provider complete the provider section of this form
- Submit the completed documents to: EHprograms@ketteringhealth.org
- Please put the type of exemption request (medical), your last name, first name, and badge number in the subject line of the email to expedite processing.

This Form requires a medical provider's signature and your signature on Page 3. You may attach medical records or additional documentation. Incomplete or unsigned submissions will not be reviewed.

Please submit all forms and documentation at one time in one email.

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Dear Healthcare Provider:

Kettering Health policy requires that all employees, employed and non-employed medical staff, volunteers, contractors, vendors, and students receive a COVID-19 vaccination. _____ (insert patient's name and Badge #) is requesting a medical exemption from this vaccination requirement.

Please certify below the medical reason that your patient should not be vaccinated for COVID-19 by completing this form. Information provided will be reviewed in consideration of the exemption request.

The individual listed above should not be immunized for COVID-19 for the following reasons (*Please check a box under the Allergy or Physical Condition/Medical Circumstance Categories*):

Allergy

☐ A severe allergic reaction to any component of a COVID-19 vaccine or to a substance that is cross-reactive with a component.

What was the reaction? _____

What prior vaccine or component caused the prior reaction that you believe will cause a severe reaction to the COVID-19 vaccine?

_____

Can any steps be taken to reduce the severity of the allergic reaction? _____

_____

☐ Immediate allergic reaction of any severity to a previous dose of the COVID-19 vaccine (provide evidence of vaccination).

On what date did the vaccine occur? _____

When did the reaction occur? _____

What was the reaction? _____

What medical treatment did the patient seek? _____

Which brand or brands of the COVID-19 vaccine is/are contraindicated and why? _____

_____

Physical Condition/Medical Circumstance

☐ The physical condition of the patient or medical circumstances relating to the individual are such that vaccination is not considered safe. Please state specific nature and probable duration of the Impairment(s) that contraindicate the COVID-19 vaccine and which vaccines are contraindicated. If the impairment is temporary, is there a date when the vaccine can be administered?

_____

_____

_____

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Certification for Medical Provider

I certify that **I am currently treating the patient**, the patient has the **clinical contraindications to the COVID-19 vaccines I have listed on Page 2 of this form**, and **I am acting within my respective scope of practice** by providing this recommendation. I am recommending that this patient be exempted from Kettering Health's COVID-19 vaccine requirement for the following vaccines:

☐ Pfizer ☐ J&J

☐ Moderna ☐ All of the Above

Medical Provider Name: _____ Date: _____

Medical Provider Signature: _____

Name of Practice: _____

Verification and Accuracy (*must be signed by the individual submitting the exemption request*):

By signing below, I am agreeing and attesting to the following statements:

1. I request an exemption from the COVID-19 vaccination requirements due to my current medical condition, a prior severe allergic reaction to the COVID-19 vaccine or a component of the COVID-19 vaccine. I understand and assume the risk of non-vaccination.
2. Should I contract COVID-19, I will immediately report it to Employee Health and comply with all procedures as specified by Employee Health Staff.
3. I acknowledge that I have read the CDC COVID-19 Vaccine Information.
4. I understand and agree to comply with and abide all Kettering Health COVID-19 policies and procedures for non-vaccinated employees.
5. I verify that the information I have provided in connection with this request is accurate and complete as of the date of submission. I understand this exemption may be revoked if it is not reasonable or creates an undue hardship on my employer. I understand that any false or incomplete information on this form may result in disciplinary action, up to and including termination for falsification of records.
6. I hereby authorize the healthcare provider who signed this form to speak with a designee from Kettering Health and potentially disclose personal medical information if such information is needed to review my exemption request.

Printed Name: _____ Badge# (if applicable): _____

Signature: _____ Date: _____