Medical Declaration for Vaccination Exemption

Employee Name: _____ Date of Birth: _____

Dear Medical Provider,

On November 5, 2021, the Centers for Medicare and Medicaid Services (CMS) enacted an emergency regulation which mandates the COVID-19 vaccination of eligible staff at health care facilities that participate in the Medicare and Medicaid programs. The above-named individual is seeking an exemption from this requirement due to medical contraindications.

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

Please list the authorized COVID-19 vaccine(s) that are clinically contraindicated for the person named above to receive and the clinical reasons for the contraindications.
This exemption should be: ☐ Temporary, expiring on: __/__/____, or when _____ ☐ Permanent

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

Licensed Practitioner Name: _____

Licensed Practitioner Signature: _____

Date: _____

License Number: _____

Phone: _____

Effective 11/2021