REQUEST FOR A MEDICAL EXEMPTION TO THE COVID-19 VACCINATION REQUIREMENT

The Centers for Medicare & Medicaid Services (CMS) requires all workers in most health care settings, including hospitals and health systems that participate in the Medicare and Medicaid programs, to be vaccinated against COVID-19, with exceptions only as required by law. In certain circumstances, Federal law may entitle a healthcare employee who meet the CDC-recognized medical contraindications to receiving a COVID-19 vaccine, which has been established by the individual's health care provider in which case the employee would instead comply with alternative health and safety protocols. Pulaski Memorial Hospital (PMH) is committed to respecting the important legal protections for medical exemptions.

In order to request a medical exception, please fill out this form. The purpose of this form is to start the accommodation process and help PMH determine whether you may be eligible for a medical exception. Forms must be filled out, signed, and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice. This documentation must contain all information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications. Additionally, a statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements is also expected.

Where there is an objective basis to do so, PMH may ask for additional information as needed to determine if you are legally entitled to an exception.

Signing this form constitutes a declaration that the information you provide is, to the best of your knowledge and ability, true and correct. Any intentional misrepresentation to PMH may result in disciplinary consequences, including termination.

I declare to the best of my knowledge and ability that the foregoing is true and correct.

Print Name: ________________________ Signature: ________________________ Date: ____________

COVID-19 MEDICAL EXEMPTION REQUEST FORM

Please complete this form in its entirety including which of the available COVID-19 vaccinations are contraindicated. The form must be signed, dated, and include a statement from the Healthcare Provider to be considered complete and able to be reviewed by the Exemption Review Committee.

Associate Name ______________________________ Employee ID #: ______________________
Department: ______________________________ Email Address: ______________________

☐ Severe allergic reaction (e.g. anaphylaxis) after previous dose or to a component of the COVID-19 vaccine:

Healthcare Provider Supporting Documentation: ____
____
____

☐ Immediate (within 4 hours of exposure) allergic reaction of any severity to a previous dose or known (diagnosed) allergy to a component of the vaccine. Documented history of severe systemic reaction episode requiring epinephrine to a COVID-19 vaccination.

Healthcare Provider Supporting Documentation: ____
____
____

☐ This patient received monoclonal antibodies and I recommend a temporary exemption be granted for 90 days from the date of treatment.

- Date of Treatment: ________________

☐ I recommend a temporary exemption for receiving the vaccine for other documented reason.

- Reason for temporary exemption: ____
- Date associate can receive vaccine: _______________

Which of the available COVID-19 vaccinations is/are contraindicated?

☐ Pfizer	☐ Moderna	☐ Jansen (Johnson & Johnson)

Statement from Healthcare Provider (Required): ____
____
____
____
____
____
____

Healthcare Provider Name: ________________________________
Healthcare Provider Signature: ______________________________ Date: ________________
Healthcare Provider Phone #: ______________________________ Fax: ________________

Authorization to Release Information (For Medically Related Reasons Only)

I am giving authorization to my healthcare provider (HCP) to release information to Pulaski Memorial Hospital and/or the organization's health representative to contact my HCP related to my medical eligibility to receive COVID-19 vaccination.

____

Employee Signature   Date

<table>
<tr><th colspan="2">Associate Health to fill out</th></tr>
<tr><td>Approved: ________ Yes ________ No ________ Date
Pending Further Review: ________ Initial Review Date ________</td><td>Employee Notified Date: ________</td></tr>
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Please return to Human Resources upon completion