

Baptist Health

Any individual in the State of Alabama who is subject to a requirement that he or she receive one or more COVID-19 vaccinations as a condition of employment may claim an exemption for medical reasons, because the vaccination conflicts with sincerely held religious beliefs, or both. You may request either a medical or a religious exemption from the COVID-19 vaccination by completing this form and submitting the form to your employer.

In the event your employer denies this request, you have a right to file an appeal with the Department of Labor within 7 days. Your employer will provide you with information on how to file an appeal.

\_\_\_\_\_ I am requesting exemption from the COVID-19 vaccine requirements for one of the following reasons: (check all that apply)

\_\_\_\_\_ My health care provider has recommended to me that I refuse the COVID-19 vaccination based on my current health conditions and medications. (NOTE: You must include a licensed health care provider's signature on this form to claim this exemption.)

\_\_\_\_\_ I have previously suffered a severe allergic reaction (e.g., anaphylaxis) related to vaccinations in the past.

\_\_\_\_\_ I have previously suffered a severe allergic reaction related to receiving polyethylene glycol or products containing polyethylene glycol.

\_\_\_\_\_ I have previously suffered a severe allergic reaction related to receiving polysorbate or products containing polysorbate.

\_\_\_\_\_ I have received monoclonal antibodies or convalescent plasma as part of a COVID-19 treatment in the past 90 days.

\_\_\_\_\_ I have a bleeding disorder or am taking a blood thinner.

\_\_\_\_\_ I am severely immunocompromised such that receiving the COVID-19 vaccination creates a risk to my health.

\_\_\_\_\_ I have been diagnosed with COVID-19 in the past 12 months.

\_\_\_\_\_ Receiving the COVID-19 vaccination conflicts with my sincerely held religious beliefs, practices, or observances.

I hereby swear or affirm that the information in this request is true and accurate. I understand that providing false or misleading information is grounds for discipline, up to and including termination from employment.

\_\_\_\_\_  
Employee's Printed Name

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Date

(Note: The following must be completed ONLY if claiming the first medical exemption listed above.) Certification by a licensed health care provider as to the accuracy of information provided above:

\_\_\_\_\_  
Name of Health Care Provider

\_\_\_\_\_  
Signature of Health Care Provider

\_\_\_\_\_  
Date