Baptist Health

MEDICAL CERTIFICATION FORM – COVID-19

REQUEST FOR MEDICAL EXEMPTION FROM COVID-19 VACCINATION POLICY

Name: _____ Date: _____

Dear Health Care Provider,

The above-named individual (your patient) has disclosed that he/she has a medical impairment(s) that renders him/her unable to comply with the federal mandate that all healthcare workers be fully vaccinated against COVID-19 and has requested an exemption/accommodation.

Please fully complete this Medical Certification Form to assist in evaluating this request, and return it to the above-named individual within ten (10) calendar days of the date above. Please do not include in your response any "genetic information," as described at the bottom of this page.[1]

Does the above-named individual have a medical impairment(s) with recognized clinical contraindications that renders them unable to receive one or more of the COVID-19 vaccines authorized or approved for use in the United States?

☐ Yes ☐ No

If you answered "No," do not answer the remaining questions, but complete and sign the "Certification" at the end of this document.

Please indicate by checking the applicable boxes below which of the COVID-19 vaccines authorized or approved for use in the United States you are recommending that the above-named individual not receive based on the individual's medical impairment(s).

☐ Pfizer ☐ Moderna ☐ Janssen / Johnson & Johnson

[1] *The Genetic Information Nondiscrimination Act of 2008 (GINA) and similar state laws generally prohibit employers and other entities covered by GINA Title II (and similar state laws) from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by law. To comply with applicable law(s), we are asking that you not provide any genetic information or results of genetic tests, as defined by applicable law(s), when responding to this request for medical information. By way of example, "genetic information" (as defined by federal law) includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.*

Please describe in detail below how the medical impairment(s) renders the individual unable to comply with the federal mandate that healthcare workers be fully vaccinated against COVID-19. Please provide at least the following information, where applicable:

- **The applicable contraindication or precaution for COVID-19 vaccination, and for each contraindication or precaution, indicate: (a) whether it is recognized by the CDC pursuant to its guidance; and (b) whether it is listed in the package insert or Emergency Use Authorization fact sheet for each of the COVID-19 vaccines authorized or approved for use in the United States;**
- **A statement that the individual's condition and medical circumstances relating to the individual are such that COVID-19 vaccination is not considered safe, indicating the specific nature of the medical condition or circumstances that contraindicate immunization with a COVID-19 vaccine or might increase the risk for a serious adverse reaction; and**
- **Any other medical condition that would limit the employee from receiving any COVID-19 vaccine.**

This vaccination exemption should be:

☐ Temporary, expiring on: ____/____/____, or when _____.

☐ Indefinite

Are there accommodations that will reduce or eliminate the threat of injury/harm posed to the individual's own health and/or safety – or the health/safety of others in the workplace – while the individual is at work given that the individual is not fully vaccinated against COVID-19?

☐ Yes ☐ No

If you answered "Yes," please describe <u>all</u> such accommodations in detail and explain how these accommodations will reduce or eliminate the threat:

CERTIFICATION

By signing below, I certify that the answers provided in response to the above questions are based on my own personal knowledge of the relevant medical facts from my own examination of the patient/individual, and/or based on my own review of the relevant medical documentation, and my answers represent my professional medical opinion in an area within my scope of medical practice.

Health Care Provider Name (print):	
Health Care Provider Signature:	Date:
Health Care Practice & Address:	Phone:
Health Care Specialty or Type of Practice:	Fax Number: