COVID-19 VACCINATION
MEDICAL EXEMPTION REQUEST

Section 1

Name (print):_____ Cell Number/Date: _____

Department: _____ Position: _____

To request an exemption from required COVID-19 vaccinations based on medical conditions, please complete Section 1 and have your medical provider complete Section 2 before returning this form to Human Resources. The completed form must be received by Human Resources on or before November 22, 2021.

I am requesting a medical exemption from OCH's mandatory COVID-19 vaccination policy or a temporary delay in complying with that policy, based on the following disability or medical condition:

_____

_____

I verify that the information I am submitting to substantiate my request for exemption from or temporary delay in complying with OCH's vaccination policy is true and accurate to the best of my knowledge. I understand that any falsified information can lead to corrective or disciplinary action, up to and including termination of employment.

I further understand that OCH is not required to provide this exemption if doing so would pose a direct threat to myself or others in the workplace or would create an undue hardship for OCH.

I understand if this request is granted, I must abide by any reasonable accommodations provided by OCH including the use of a facial mask, social distancing and COVID testing.

Employee Signature:	Date:

Section 2

Medical Certification for Vaccination Exemption

Employee Name: _____

Dear Medical Provider,

OCH requires covered staff members to be fully vaccinated against COVID-19 as a condition of employment or qualification to provide services for it. The individual named above is seeking an exemption to this policy due to a medical condition or seeking to delay vaccination because of a temporary condition or medical circumstance. Please complete this form to assist OCH in the reasonable accommodation process.

_____ has been a patient under my care since _____ and was last seen in my office on _____.

Please include in your responses all information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the above-named individual to receive and the recognized clinical reasons for the contraindication and sign and date the form where indicated.

For each of the authorized COVID-19 vaccines listed below, please indicate whether the vaccine is clinically contraindicated for the person named above and the recognized clinical reasons for any such contraindications:

- ☐ **Pfizer vaccine: The person named above MAY NOT receive the Pfizer vaccine based on the following recognized clinical reason:**
  _____
- ☐ **Moderna vaccine: The person named above MAY NOT receive the Moderna vaccine based on the following recognized clinical reason:**
  _____
- ☐ **Johnson & Johnson vaccine: The person named above MAY NOT receive the Johnson & Johnson vaccine based on the following recognized clinical reason:**
  _____

This exemption should be:

- ☐ Temporary, expiring on: __/__/____, or when _____
- ☐ Permanent

I certify the above information to be true and accurate. I recommend that the person named above be exempted from OCH's COVID-19 vaccination requirements based on the above stated recognized clinical contraindications.

Medical Provider Name (print):	
Medical Provide Signature:	Date:
Practice Name & Address:	Provider Phone:

EMPLOYEE ATTESTATION:

I certify that the above information is true and correct, and that I am applying to obtain a medical exemption from OCH's federally required COVID-19 vaccination requirement.

Employee Signature: _____ Date: _____

REVIEW:

☐ Approved

☐ Denied

☐ Requested the following additional information on the following date:

_____

_____

_____

_____

_____

_____ _____

Signature of Reviewing Official Date