

Medical Exemption Request Covid-19 Vaccination – Colorado

Colleague Information

Printed Name: _____ 3-4 ID: _____

Date: _____

If you wish to request a medical exemption from mandatory vaccination, please sign the attestation below:
I have a medical condition or disability that prevents me from taking any of the COVID-19 vaccines authorized by the FDA. To be eligible for this exemption, I understand that I must provide to my employer (or to the facility where I volunteer or otherwise work) a written statement signed by my healthcare provider, that I qualify for the exemption and indicating the probable duration of my inability to receive the vaccine (or indicating that the duration is unknown).

Employee Signature: _____ Date: _____

Healthcare Provider Information

Printed Name: _____ Provider Specialty: _____

License Number: _____ Phone Number: _____

Licensed Healthcare Provider: Please mark the contraindications / precautions or other medical condition / disability that apply to this patient and sign and date this form. Licensed Healthcare Provider must include either a treating physician (M.D. or D.O.) or treating advanced practice professional (nurse practitioner or physician assistant or certified nurse midwife). **Note: Health Care Providers cannot sign their own exemption / certification request. *Providers are also subject to randomized review following the submission of exemption request from the patient. ***

<p>Vaccine Contraindication Certification (list all that apply) – Requires healthcare provider signature Note – Contraindication to one vaccine does not preclude receipt of another vaccine type</p>	
<p>Johnson & Johnson</p>	<p><input type="checkbox"/> Known history of severe allergic reaction (anaphylaxis) to any component of the vaccine or immediate allergic reaction</p> <p><input type="checkbox"/> Previous history of heparin-induced thrombocytopenia (HIT)</p> <p><input type="checkbox"/> Contraindication to MRNA vaccines (must specify below) AND female under age of 50</p> <p><input type="checkbox"/> Other _____ (must provide specifics)</p>

<p>mRNA Pfizer or Moderna</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Known history of severe allergic reaction (anaphylaxis) to any component of the vaccine or immediate allergic reaction <input type="checkbox"/> Known history of severe reaction (anaphylaxis) to the first dose of either mRNA vaccine <input type="checkbox"/> Previous history of Multisystem Inflammatory Syndrome (MIS) of adults or children <input type="checkbox"/> Documented Myocarditis after first dose of mRNA vaccine <input type="checkbox"/> Other _____ (must provide specifics)
<p>Deferral Certification – <i>Requires healthcare provider signature</i></p>	
<p>General (Request for Deferral)</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Acute COVID-19 infection. Vaccination will be received once individual has recovered from acute illness if symptomatic and met requirements to discontinue isolation. <input type="checkbox"/> Receipt of monoclonal/polyclonal COVID-19 antibody treatment within the past 90 days* <input type="checkbox"/> Receipt of convalescent plasma treatment within the past 90 days* <p>*Deferral timeframe needed from provider for when employee can receive vaccination. *</p> <p>Date employee can be vaccinated: _____</p>

I attest that I have a healthcare provider-patient relationship with the candidate identified above and that the above statements are true and accurate.

Healthcare Provider Signature: _____ Date: _____

This exemption request has been:

- Approved**
- Denied**

If your request is approved, you will be required to participate in mitigation practices as required by your Hospital. If your request is denied, you will be notified by Human Resources.