Human Resources Department
COVID-19 Vaccination Program Policy A-34
Medical Exemption Request Form
FY 2021-2022

CATAWBA VALLEY MEDICAL CENTER

Staff Information			
Name	**Position Title**	**Department**	**Request Date**
Phone Number(s)		**Personal Email Address:**	

Medical Exemption Request Process Information and Instructions

- Staff seeking exemption from the COVID-19 vaccination due to medical contraindication must complete this Request for Medical Exemption form.
- **The form must be fully completed with sufficient supporting information attached and submitted to Betty Rhoney, Human Resources Compliance Manager by no later than MONDAY, JANUARY 24, 2022, 12:00 PM.**
- All information requested and all questions must be answered for your request to be considered.
- Staff requesting exemption due to medical contraindication may be required to provide additional supporting information, including medical records confirming the contraindication.

The following information is required (check one that applies to you):

- ❑ I am an employee of Catawba Valley Medical Center
- ❑ I am a student or trainee at Catawba Valley Medical Center
- ❑ I am a volunteer at Catawba Valley Medical Center
- ❑ I am employed by a company that provides services for Catawba Valley Medical Center or its patients
- ❑ I am a self-employed contractor who provides services for Catawba Valley Medical Center or its patients
- ❑ I am a member of the medical staff with admitting privileges or who sees patients at Catawba Valley Medical Center and am **NOT** an employee of Catawba Valley Medical Center
- ❑ None of the above (explain your role): _____

Staff/Requestor Acknowledgement

By signing this request for exemption, I acknowledge that I understand the following:

- On November 5, 2021, the Centers for Medicare & Medicaid Services (CMS) issued a requirement for full vaccination against COVID-19 for staff at hospitals and other covered health care organizations to prevent the spread of COVID-19 and its complications, including death. The Centers for Disease Control and Prevention (CDC) and Occupational Safety and Health Administration (OSHA) also have issued recommendations for vaccination against COVID-19.
- In accordance with federal law, CVMC requires all Staff to be fully vaccinated against COVID-19 unless approved for a medical or religious exemption.
- I understand that if I am granted exemption from the vaccination requirement, I will be subject to additional precautions intended to mitigate the transmission and spread of COVID–19 for Staff who are not fully vaccinated, and I must comply with all other applicable universal infection control precautions as well as the additional precautions for Staff who are not fully vaccinated. Additional precautions may include but are not limited to source control measures such as wearing an N95 mask at all times while on CVMC premises, restrictions on presence in common or other areas where risk of transmission may be greater and undergoing periodic COVID-19 testing. My failure to consistently comply with these requirements will result in disciplinary action up to and including termination of employment or service.

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Staff/Requestor Acknowledgement		
Print Name	**Signature**	**Date**

To Be Completed by Medical Provider	
NOTE TO PROVIDER: Medical records establishing the existence of the contraindications, reactions and conditions may be required to support the exemption request.	
Full Name of Individual/Patient Requesting Medical Exemption	

Exemption requests for reasons other than ACIP and manufacturer recommended vaccine contraindications listed above will be reviewed by an independent practitioner to evaluate the exemption request, and provider must include all information specifying why all COVID-19 vaccines are clinically contraindicated with this certification.

Medical Provider Certification

I, the undersigned health care provider, certify that the individual named above is my patient and has a contraindication that warrants a medical exemption from the COVID-19 Vaccine due to:

- ❑ Documented anaphylaxis or life-threatening allergic reaction***** **to prior COVID vaccine**.

  Date of allergic reaction: _____
  Vaccine: _____
  Name, address, phone of provider treating the allergic reaction:

- ❑ Documented anaphylaxis or life-threatening allergic reaction***** to any of the vaccine components.

  Date of allergic reaction: _____
  Vaccine component: _____
  Name, address, phone of provider treating the allergic reaction:

Name of the specific COVID-19 vaccines which are clinically contraindicated for this person:

* Documented anaphylactic or life-threatening allergic reaction or other severe adverse reaction generally does not include gastro-intestinal symptoms, sore arm, local reaction, or subsequent respiratory tract infection as the sole presentation of allergy.

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I do hereby attest that: (i) this medical exemption is based upon true and accurate medical information that I have as this person's medical provider; (ii) based on this information, I am recommending this person be exempted from all COVID-19 vaccines; and (iii) in making this determination and recommendation, I am acting within my respective scope of practice based on applicable state and local law.			
Printed Provider Name	**Provider Signature**	**State/License Number**	**Date**
MD DO PA NP CNM (Circle One)	**Provider Address:**	**Provider Phone:**	**Provider Fax:**
Type of Practice/Medical Specialty			

CVMC Determination Review Process
The COVID-19 Vaccination Exemption Committee has completed a review of the Medical Exemption Request and has made the following determination:
❑ **Approved (describe any conditions of approval):**
❑ **Denied**
❑ **The following further actions/information are needed in order to make a determination:**

COVID-19 Vaccination Exemption Review Adjudicating Official			
Print Name	**Signature**	**Position**	**Determination Date**

Notification Verification Process		
Notification Date to Requestor/Sender's Name	**Communication Method**	
	Email	**US Postal Service**

Appeal Process
Date Appeal Submitted:
Reviewer(s) Names:
❑ **Denial Affirmed** ❑ **Denial Reversed**

Appeal Notification Process		
Notification Date to Requestor/Sender's Name	**Communication Method**	
	Email	**US Postal Service**