Help at Home
Care to Live Your Life.

Employee Request for a Medical Exemption from COVID-19 Vaccine Form

Help at Home's policy requires that all associates provide documentation of COVID-19 vaccination. A medical exemption may be valid upon receipt of a completed form (below) not more than 6 months old, signed and certified by a licensed health care provider, not related to the submitter, and whose specialty is appropriate to the associated condition.

Medical exemptions expire when the medical condition(s) contraindicating COVID-19 vaccination changes in a manner which permits vaccination or determined by Help at Home. The assigned expiration is at the sole determination of Help at Home.

Individuals with an approved exemption may be required to comply with COVID-19 testing and other preventive requirements based on state, local, and/or Help at Home policy and as may be updated by later notification and/or posting of requirements on the Help at Home website.

The COVID Vaccination Committee will carefully review all requests, though approval is not guaranteed. After your request has been reviewed and processed, you will be notified, in writing, if an exemption has been granted or denied. You may appeal the decision of the committee. The findings and decisions by the appeals committee shall be final. Individuals are permitted to reapply if new documentation and information should become available.

To submit a request, please:

- Read the CDC COVID-19 Vaccine Information;
- Complete and sign the following pages of this form;
- Have your licensed health care provider complete the provider section of this form

and

- Submit the completed documents.

Incomplete submissions will not be reviewed. Be sure all forms and documentation are submitted at one time.

Initial next to each of the statements below:

_____ I request exemption due to my current medical condition. I understand and assume the risks of non-vaccination. I accept full responsibility for my health, thus removing liability from Help at Home with respect to vaccinations.

_____ I understand that as I am not vaccinated, in order to protect my own health and the health of the community, I will comply with assigned COVID-19 testing requirements and other preventive guidance requirements for unvaccinated individuals.

_____ I authorize my licensed healthcare provider to provide Help at Home with medical information about my medical exemption for the COVID-19 vaccination.

_____ I understand that this exemption will expire when the medical condition(s) contraindicating vaccination changes in a manner which permits vaccination, as determined by Help at Home.

_____ Should I contract or have an exposure to COVID-19, I will immediately report it to the assigned Help at Home leadership and comply with all isolation and quarantine procedures specified by Help at Home.

_____ I acknowledge that I have read the CDC COVID-19 Vaccine Information. Coronavirus Disease 2019 (COVID-19) | CDC

_____ I certify the information I have provided in connection with this request is accurate and complete. I understand this exemption may be revoked and I may be subject to Help at Home's disciplinary action if any of the information I provided in support of this exemption is false.

Printed Name: _____
Signature: _____
Employee ID: _____
Date: _____
Phone Number:_____
Email: _____

☐ By checking this box and typing my name above, I understand and agree that I am submitting this document electronically and that it is the legal equivalent of having placed my handwritten signature on the submitted document.

Date: _____

Allopathic or Osteopathic (MD/DO) Physician's Statement:

Help at Home's policy requires that all employees submit a Covid-19 Confirmation.

_____ is requesting a medical exemption from this policy. A medical exemption may be allowed for certain recognized contraindications.

Please certify below the medical reason your patient should not be vaccinated for COVID-19 by completing this form and attaching available supporting documentation. Information provided on this form will be reviewed in consideration of the exemption request.

Option 1 - Allergy

- A documented history of a severe allergic reaction to any component of a COVID-19 vaccine or to a substance that is cross-reactive with a component. Please indicate which of the following vaccines are contraindicated and name the components, by vaccine
    - Moderna - List the component(s): _____
    - Pfizer - List the component(s): _____
    - Janssen/Johnson & Johnson - List the component(s): _____
- A documented history of a severe allergic reaction after a previous dose of the COVID-19 Vaccine. Please indicate to which vaccine the patient had a reaction and the date of the vaccine & reaction.
    - Moderna - Date of Vaccine & Reaction: _____
    - Pfizer - Date of Vaccine & Reaction: _____

Option 2 – Physical Condition/Medical Circumstance

- The physical condition of the patient or medical circumstances relating to the individual are such that vaccination is not considered safe. Please state, with sufficient detail for independent medical review, the specific nature and probable duration of the medical condition or circumstances that contraindicate vaccination with the COVID-19 vaccine.

Explanation: _____

_____

Option 3 - Other

- Other. Please provide this information in a separate narrative that describes, in detail, the medical condition or disability in detail that would contraindicate vaccination:

Explanation: _____

_____

CERTIFICATION

I certify that _____. __has the above contraindication and support the request for a medical exemption from the COVID-19 vaccine policy.

PROVIDER INFORMATION

Physician Name: _____

Physician Specialty: _____

Signature: _____

Physician License Number: _____

Date: _____

Practice Name: _____

Address: _____

Email: _____

Practice Phone number: _____

PATIENT INFORMATION

Patient Name: _____

Date: _____

Employee ID: _____

Patient Email: _____

Patient Phone number: _____