Methodist Le Bonheur Healthcare

Vaccine Medical Exemption Form – COVID-19 Vaccine			
Date of Request:		SAP#/Cactus:	Facility/Cost Ctr:
Requestor Name:		Status:	
Requestor Phone:		Requestor Email:	
Requestor's Medical Provider's Name		Requestor's Medical Provider Phone:	
Immediate Supervisor:		Job Title:	

If you have an allergy to the COVID-19 vaccine or a specific medical condition that precludes the COVID-19 vaccination requirement and you seek a medical exemption, please consult with your medical provider and submit this completed form to AssociateHealth@mlh.org.

Note to the medical provider: Methodist Le Bonheur Healthcare requires the COVID-19 vaccination for all Associates and providers. A medical exemption from COVID-19 vaccination is allowed for certain recognized contraindications. https://www.cdc.gov/vaccines/covid-19/downloads/summary-interim-clinical-considerations.pdf Of note, the COVID-19 vaccination of pregnant and breastfeeding women is recommended by the CDC. https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html#pregnant

TO BE COMPLETED BY a medical provider:

Please check all that apply:

☐ Severe allergic reaction (anaphylaxis requiring epinephrine) after a previous dose or to a component of the COVID-19 vaccine. If checked, answer the following questions.

Do you recommend this patient be exempted from MLH vaccine requirement?

Which ingredient caused an allergic reaction?

What was the reaction?

Which brand of the COVID-19 vaccines is contraindicated and why?

- ☐ Pfizer; Why?
- ☐ Moderna; Why?
- ☐ J&J; Why?
- ☐ Other; Why?

How long with the medical contraindication last?

- ☐ Lifetime
- ☐ Other:

If not all brands are contraindicated, have you recommended another brand of COVID-19 vaccine?

If yes, which vaccine did you recommend?

If not, please explain the medical contraindication for the alternate brands of COVID-19 currently available?

☐ Immediate systemic allergic reaction of any severity to a previous dose or known (diagnosed) allergy to a component of the vaccine. (Vaccine ingredients: https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html#Appendix-C)

Do you recommend this patient be exempted from MLH vaccine requirement?

Which ingredient caused an allergic reaction?

What was the reaction?

Which brand of the COVID-19 vaccines is contraindicated and why?

- ☐ Pfizer; Why?
- ☐ Moderna; Why?
- ☐ J&J; Why?
- ☐ Other; Why?

How long with the medical contraindication last?

- ☐ Lifetime
- ☐ Other:

If not all brands are contraindicated, have you recommended another brand of COVID-19 vaccine?

If yes, which vaccine did you recommend?

If not, please explain the medical contraindication for the alternate brands of COVID-19 currently available?

☐ Other medical reason – Please describe the other medical reason justifying an exemption in detail.

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Do you recommend this patient be exempted from MLH vaccine requirement?

Which brand of the COVID-19 vaccines is contraindicated and why?

- ☐ Pfizer; Why?
- ☐ Moderna; Why?
- ☐ J&J; Why?
- ☐ Other; Why?

How long with the medical contraindication last?

- ☐ Lifetime
- ☐ Other:

If not all brands are contraindicated, have you recommended another brand of COVID-19 vaccine?

If yes, which vaccine did you recommend?

If not, please explain the medical contraindication for the alternate brands of COVID-19 currently available?

Provider Name (Please Print): _____

Provider Title: _____

Provider License Number:_____ State of License: _____

Provider Specialty: ☐ Internal Medicine ☐ Family Practice ☐ OBGYN ; Other: _____

Provider employer/affiliation:

Provider Signature: _____ Date:_____

Requestor to complete the below (Associate/Volunteer/other Workforce)

I certify that the above information is complete and accurate and I understand that any intentional misrepresentation contained in this request may result in corrective action. I understand that if I am granted this exemption, I may be required to comply with additional safety measures per policy such as masking/distancing.

Requestor Signature: _____ Date: _____