VNSNY Partners in Care

VNSNY Request for Medical Exemption from the COVID-19 Vaccination Mandate

Employee Name:	Job Title/Department:
Employee ID:	Employee Phone:

INSTRUCTIONS: Use this form to request a medical exemption and/or accommodation in connection with the COVID-19 Vaccine Mandate. You will be required to timely submit to Health Services a detailed medical note describing the contraindication/basis for exemption.

1. Basis for Exemption/Accommodation (check all that apply) (Required)

   ☐Documented history of severe allergic reaction to a component of a COVID-19 vaccine/cross-reactivity to a component

   ☐Documented history of severe allergic reaction *after* a previous dose of the COVID-19 vaccine

   ☐Immunization not considered safe due to physical condition/medical circumstance

   ☐Other- please describe:

2. Is the basis selected above expected to be temporary in duration?

   ☐Yes

   ☐No

Please submit the **Health Care Provider Certification** below. You should print this form and present it to your Health Care Provider as soon as possible for completion.

Your request for exemption will not be reviewed until this form is completed by your Health Care Provider and submitted to Partners in Care Health Services.

- Fax: 212-290-3184
- Email: PAR_EmployeeHealthServices@vnsny.org

Please allow up to 10 business days from submission of the Health Care Provider Certification for the determination of your request for exemption from the COVID-19 Vaccine mandate.

If your request for exemption is not approved by October 7th, you will be removed from the active workforce and will not be able to work.

If you have questions, please email PAR_EmployeeHealthServices@vnsny.org.

VNSNY Partners in Care

Health Care Provider’s Certification of Medical Exemption from COVID-19 Vaccine Mandate

Employee Name:	Job Title/Department:
Employee ID:	Employee Phone:

INSTRUCTIONS: A medical exemption may be granted 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 immunization changes in a manner that permits immunization. VNSNY may require individuals with an approved exemption to comply with additional testing and other preventive requirements.

By signing below, I hereby certify that the below information provided is true and correct to the best of my knowledge. I understandany false information will disqualify any prior approval.

Employee’s Signature:_______________________ **Date:**______/______/_______

TO BE COMPLETED BY YOUR HEALTH CARE PROVIDER:

Attention Health Care Provider:

____ (insert patient’s name) is requesting a medical exemption from a vaccination requirement. A medical exemption may be allowed for certain recognized contraindications. Please certify the medical reason that your patient should not be immunized for COVID-19 by completing this form and attaching available supporting documentation.

(Continue to next page)

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 NOTE: since egg-free vaccine is available, history of egg allergy will not be accepted as a routine medical exemption.

- 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 and reaction.

- Moderna - Date of Vaccine & Reaction: ____
- Pfizer - Date of Vaccine & Reaction: ____
- Janssen/Johnson & Johnson - 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 immunization 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 immunization with the COVID-19 vaccine:

____

____

Option 3 - Other

__ Other. Please provide this information in a separate narrative that describes, in detail, the medical condition or disability in detail that you opine would exempt this individual from vaccination:

Explanation: ____

____

(Continue to next page)

Health Care Provider Certification

I certify that_______________________________________(patient name) has the above contraindication and supportthe request for a medical exemption from a COVID-19 vaccine requirement.

Provider Information

Medical Provider Name	
Medical Provider Specialty	
Medical Provider Signature	
Medical Provider License Number	
Date	
Name of Medical Provider's Company	
Email	
Phone Number	

Once completed, this entire form should be returned to the Partners in Care Health Services Department.

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- Email: PAR_EmployeeHealthServices@vnsny.org