Medical Certification for COVID-19 Vaccination Exemption

Employee /Patient Name: _____

Date of Birth: _____

Dear Medical Provider:

Jefferson Regional is required to have vaccination against COVID-19 as a condition of CMS. The individual named above is seeking an exemption to this policy due to medical contradictions.
Please complete this form to assist Jefferson Regional in the reasonable accommodations process.

NOTE: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers from obtaining genetic information as to any employee or family member except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family members receiving assistive reproductive services.

(Below must be completed and signed by Medical Provider)

The person named above should not receive the COVID-19 vaccine due to:

_____

_____

_____

This exemption should be:
☐ Temporary, expiring on: __/__/_____, or when_____ ☐ Permanent

This exemption applies to the: ☐ Pfizer-BioNTech Vaccine ☐Moderna TX, Inc. Vaccine

☐ Johnson & Johnson Vaccine (check all that apply)

I certify that I have reviewed the medical records of the above-named patient and I certify the above information to be true and accurate and request exemption from the COVID-19 vaccine for the above individual.

Medical Provider Name (print)	
Medical Provider Signature:	Date:
Practice Name & Address:	Provider Phone:

(Below must be completed and signed by Employee/Patient)

I the Employee/Patient understand not being vaccinated as the result of an exemption will require me to wear a surgical mask whenever present in a Jefferson Regional facility, and I understand I will be subject to frequent COVID-19 testing regardless of whether I am a direct patient caregiver, and a corrective action will be taken against me if I fail to abide by the masking and testing requirements.

Employee/Patient Name (print)	
Employee/Patient Signature	Date:

For Jefferson Regional HR use only:

Approved_____ Not Approved _____