REQUEST FOR A MEDICAL DELAY/EXEMPTION FROM THE COVID-19 VACCINATION REQUIREMENT

Part 1- To be Completed by the Individual requesting medical delay/exemption	
Name	**Date of Request**
Phone	**E-mail**

Medical or Disability Exemption Request	
I am requesting a medical exemption to the requirement for COVID-19 vaccination because of a medical contraindication or medical condition or a delay because of a medical condition. I declare that the information I have provided is true and correct to the best of my knowledge and ability. Signing this form constitutes a declaration that the information I provide is true and correct to the best of my knowledge and ability. Any intentional misrepresentation to Covenant Health may result in referral to Covenant School of Nursing Leadership.	
Signature	
Print Name	**Date**

A radiography student performing services at a facility that is part of Covenant's family of organizations may request an exemption from receiving the COVID-19 vaccine because of a medical contraindication and/or a medical condition that prevents the provider from safely receiving the vaccine. Radiography students who request an exemption because of a medical contraindication and/or a medical condition must have the form on the next page completed and signed by a health care provider licensed in Texas or New Mexico.

Part 2- To be Completed by the Individual's Medical Provider (may not be completed by the individual requesting the medical delay/exemption)

Name of Individual requesting medical delay/exemption

Medical Certification for COVID-19 Vaccine Exemption

Dear Medical Provider:

CMS requires hospital caregivers to be fully vaccinated against COVID-19. The individual named above is seeking a medical exemption to the requirement for COVID-19 vaccination because of a medical contraindication or medical condition or a delay because of a medical condition. Please complete this form to assist Covenant Health in its reasonable accommodation process. **By signing this form, you are certifying that you currently licensed in the State of Texas or New Mexico as an MD, DO, PA or NP.** Please provide at least the following information, where applicable:

1. The applicable medical contraindication for COVID-19 vaccination, and for each contraindication, indicate: (a) whether it is recognized by the CDC pursuant to its guidance*; and (b) whether it is listed in the package insert or Emergency Use Authorization fact sheet for each of the COVID-19 vaccines authorized or approved for use in the United States;
2. A statement that the individual's condition and medical circumstances relating to the individual are such that COVID-19 vaccine or might increase the risk for a serious adverse reaction; and
3. Any other medical condition that would limit the employee from receiving any COVID-19 vaccine.

Description of the medical condition for which the individual listed above should be exempted from complying with a COVID-19 vaccination requirement:

The condition described above is temporary ____ or long term _____.

If this is a temporary condition or medical circumstance, when it is expected to end or expire (allowing for COVID-19 vaccination to begin after the date you provided):

Medical Provider Name/Title

Medical Provider Signature	**Date**

*A contraindication is anything (including a symptom or medical condition) that is a reason for a person to not receive a particular treatment or procedure because it may be harmful.

CDC considers a history of the following to be a contraindication to vaccination for COVID-19 vaccines:

- Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a component of the COVID-19 vaccine.
- Immediate allergic reaction of any severity to a previous dose or known (diagnosed) allergy to a component of the vaccine.

COVID-19 vaccines do not contain egg or gelatin, allergies to these substances are not a contraindication.

CDC does NOT consider the following as contraindications to COVID-19 vaccination:

- Local injection site reactions after (days to weeks) previous (COVID-19 vaccines) (e.g., erythema, induration, pruritus, pain, etc.)
- Expected systemic vaccine side effects in previous COVID-19 vaccines (e.g., fever, chills, fatigue, headache, lympadenopathy, vomiting, diarrhea, myalgia, arthralgia)
- Vasovagal reaction after receiving a dose of any vaccination
- Being an immunocompromised individual or receiving immunosuppressive medications
- Autoimmune conditions, including Guillain-Barre Syndrome
- Allergic reactions to anything not contained in COVID-19 vaccines, including injectable therapies, food, pets, venom, environmental allergens, oral medication, latex, etc.
- Breastfeeding or pregnancy
- Immunosuppressed person in individual's household
- Alpha-gal syndrome