REQUEST FOR MEDICAL EXEMPTION FROM COVID-19 VACCINATION

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 physician and provide the following information.

Please print the following information:

Name:____**Date:**______________________________

Physician Name:___________________________________ **Physician Phone No.:** _______________________

Physician Address: ____

Dear Physician:

A medical exemption from COVID-19 vaccination is being requested by our employee who indicates being under your care. In order for DPI to explore any accommodations that may be made, we appreciate your completing. Thank you.

The above person should not be immunized for COVID-19 for the following reasons (Please check all that apply):

❒ 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 (Vaccine Ingredients):

Which ingredient caused an allergic reaction? _____________________________________

What was the reaction? ____

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

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How long will the medical contraindication last? ____

❒ Other Medical Reason – Please provide this information in a separate narrative that describes the other medical reason justifying an exemption in detail.

FOR THE PHYSICIAN

I certify that___________________________________**has the above contraindication or specific medical condition and request a medical exemption from COVID-19 vaccination.**

Physician Signature:____**Date:** ____________________

(Note: Signature Stamp Not Acceptable)

Physician Medical License No.:______________________________**NPI No.:** _____________________

FOR THE REQUESTOR (Employee)

I verify that the above information I have provided is complete and accurate to the best of my knowledge, and I understand that any intentional misrepresentation contained in this request may result in disciplinary action which may include termination/dismissal (employees). My request for an exemption from the COVID-19 vaccination requirement is based upon the medical reason described above. I understand that my request for an exemption may not be granted if it creates an undue hardship for the company.

Signature:____**Date:**______________________

Print Name: ____

Confidentiality of Information Provided

Requests for exemptions and any documents provided will be kept confidential and shared only with DPI representatives who have a need to know.