HEALTHTRUST
Workforce Solutions

COVID19 Medical Exemption Request Form rev 4-6-22

For use in States outside of California

Verified Professional Information–*To be completed by self only (delegates may not sign for the VPro)*

Verified Professional's Printed Name		Date	Month	Day	Yr
3-4 ID: *If applicable*					

INSTRUCTIONS: Carefully read information below regarding masking expectations of you when accessing HCA Healthcare sites. Your completion of this form and your signature is required wherever noted on this form. Incomplete forms, will be rejected. We appreciate your understanding and cooperation with this patient safety compliance initiative.

HCA Healthcare and HealthTrust Workforce Solutions Verified Professionals strongly recommends that all healthcare workers receive the COVID-19 vaccination series. However, if you have been granted an exemption, there are specific requirements that must be adhered to while in the clinical setting.

- Protect yourself and others by maintaining distance from others whenever possible.
- Approved Exemption HCW's **must wear** an approved respirator in any clinical areas when community transmission levels are high*.
  - Respirator: A respirator is a personal protective device that is worn on the face, covers at least the nose and mouth, and is used to reduce the wearer's risk of inhaling hazardous airborne particles (including dust particles and infectious agents), gases, or vapors. Respirators, including those intended for use in healthcare are certified by the CDC/NIOSH.
  - Guidance for non-fit-tested N-95 Respirators can be found using the link in Resources section of this email communication.
  - *Respirators are the highest form of respiratory protection in clinical care and are recommended by the CDC as a source-control measure for HCW's who are not vaccination from COVID-19.
- It is recommended that unvaccinated healthcare workers not care for immunocompromised patients.
- Unvaccinated and fully vaccinated healthcare workers should continue to universally mask with medical grade masks while at work for source control, maintain appropriate physical distancing while interacting with coworkers, and follow the recommended transmission-based precautions while caring for patients or residents.
- If you are feeling ill, please stay home. Do not report to work if you have any signs consistent with COVID-19 measured or subjective fever) or symptoms (e.g., cough, shortness of breath, sore throat, muscle aches, headache, loss of taste or smell). If you develop fever or respiratory symptoms at work, isolate yourself immediately, leave work and report symptoms to your supervisor or occupational health services before departure.
- Refer to your facility policy for specific guidance.
- Local/State regulations supersede this guidance **if** more stringent.
- Even after receiving an exemption approval, you may decide to receive your vaccination. Please visit http://www.vaccines.gov to find a vaccination location near you.
- Should you receive your COVID-19 vaccination, you may upload the documentation at www.hwsverified.com.

Signature by Verified Professional		Date	Month	Day	Yr

- **Please note, as a part of the exemption quality process, a secondary review of your exemption request may occur, and you may be contacted for additional follow-up.**
- **If your request form is denied, you will be informed.**

Resources:

- *OSHA - Protecting Workers: Guidance on Mitigating and Preventing the Spread of COVID-19 in the Workplace- https://www.osha.gov/coronavirus/safework*
- *CDC – COVID-19 - https://www.cdc.gov/coronavirus/2019-ncov/index.html*
- *CDC – Clinical Care Information for COVID-19 - https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-care.html*
- *CDC – Infection Control https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html*

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Verified Professional's Printed Name		**Date**	**Month**	**Day**	**Yr**
3-4 ID: ***If applicable***					

If you wish to request a medical exemption from mandatory vaccination, please sign the attestation below.

I have a medical condition or disability that prevents me from taking any of the COVID-19 vaccines authorized by the FDA. To be eligible for this exemption, I understand that I must provide to my employer (or to the facility where I volunteer or otherwise work) a written statement signed by my licensed healthcare provider, that I qualify for the exemption and indicating the probable duration of my inability to receive the vaccine (or indicating that the duration is unknown).

Please note, as a part of the exemption quality process, there may be follow-up review of this exemption. You will receive an email notifying you of approval/declination of your request.

If this request is approved, you will be required to practice universal masking in the workplace unless actively eating or drinking. Please follow local or state and/or facility guidance for testing as part of this exemption. If your request is denied, you will either need to receive the COVID-19 vaccination or access will be terminated.

Signature by Verified Professional		**Date**	**Month**	**Day**	**Yr**

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Healthcare Provider Information – *All sections of this form must be completed by the healthcare provider*

All information must be completed

Healthcare Provider Printed Name:		**Provider Specialty:**	
NPI:		**Phone Number:**	

Licensed Healthcare Provider: Please mark the contraindications / precautions or other medical condition / disability that apply to this patient and sign and date this form. Licensed Healthcare Provider must include either a treating physician (M.D. or D.O.) or treating advanced practice professional (nurse practitioner or physician assistant). **Note: Health Care Providers cannot sign their own exemption / certification request. *Providers are also subject to randomized review following the submission of exemption request from the patient.***

Vaccine Contraindication Certification (list all that apply) – ***Requires healthcare provider signature*** **Note – Contraindication to one vaccine does not preclude receipt of another vaccine type**		
Johnson & Johnson		Known history of severe allergic reaction (anaphylaxis) to any component of the vaccine or immediate allergic reaction
		Previous history of heparin-induced thrombocytopenia (HIT)
		History of Guillain-Barre Syndrome post-vaccine
		Contraindication to MRNA vaccines (must specify below) AND female under age of 50
		My patient has a physical or mental impairment that substantially limits one or more major life activities and prevents the patient from safely receiving the vaccine. **(More detail regarding the medical condition and how it prevents the patient from receiving the vaccine must be attached).**
	Additional Information:	
mRNA Pfizer or Moderna		Known history of severe allergic reaction (anaphylaxis) to any component of the vaccine or immediate allergic reaction
		Known history of severe reaction (anaphylaxis) to the first dose of either mRNA vaccine
		Previous history of Multisystem Inflammatory Syndrome (MIS) of adults or children
		Documented Myocarditis after first dose of mRNA vaccine
		My patient has a physical or mental impairment that substantially limits one or more major life activities and prevents the patient from safely receiving the vaccine. **(More detail regarding the medical condition and how it prevents the patient from receiving the vaccine must be attached).**
	Additional information:	

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All sections of this form must be completed by the healthcare provider
All information must be completed

Deferral Certification – *Requires healthcare provider signature*		
General (Request for Deferral)		Acute COVID-19 infection documented in the past 90 days
		Receipt of monoclonal/polyclonal COVID-19 antibody treatment within the past 90 days
		Receipt of high titer COVID-19 antibody treatment (Convalescent Plasma) within the past 90 days
	Deferral timeframe needed from provider for when colleague can receive vaccination. ****Colleague refers to Vendor/Verified Professional/Clinician/Etc. who is credentialed with HealthTrust VPro or Workforce 2.0*** **Date Verified Professional can be vaccinated: To be completed by Healthcare Provider Only** — **Month** / **Day** / **Year** Additional information:	

I attest that I have a healthcare provider-patient relationship with the individual identified above and that the above statements are true and accurate.

Healthcare Provider Signature:			
Healthcare Provider Printed Name:			
Date:	**Month**	**Day**	**Year**