REQUEST FOR A MEDICAL EXCEPTION TO THE COVID-19 VACCINATION REQUIREMENT

CMS policy requires all Long-Term Care Facility employees to be vaccinated against COVID-19, with exceptions only as required by law. Employees may seek a medical exemption to the vaccination requirement using the form below. The organization may request additional information as needed.
An employee may also request a delay for complying with the vaccination requirement based on certain medical considerations that may justify a temporary exception to the requirement. Employees who are granted a medical exemption or an approval for a delay from the vaccination requirement will be required to comply with alternative health and safety protocols such as frequent COVID-19 testing per organization policy and procedure. Signing this form constitutes a declaration that the information you provide is true and correct to the bestof your knowledge and ability. Any intentional misrepresentation to the organization may result in legal consequences, up to and including termination.

To request a medical exemption or delay from the COVID-19 vaccination requirement using this form:

1. You must complete Part 1 of this form.
2. Your medical provider must complete Part 2 of this form.
3. When both are completed, you must submit the form to your administrator or human resources.

All information submitted will be kept in strict confidence and will only be shared with surveyors and/or regulatory agencies to demonstrate compliance with CMS regulations.

Part 1 – To Be Completed by the Employee

Employee Name	**Date of Request**

Department/Position	**Supervisor**	**Phone Number**

Medical Exemption Request
I am requesting a medical exemption to the requirement for COVID-19 vaccination or a delay because of a temporary condition or medical circumstance. I declare that the information I have provided is true and correct to the best of my knowledge and ability.
Employee Signature

Print Name	**Date**

Part 2 – To be Completed by the Employee's Medical Provider (Must be a Licensed Practitioner who is not the individual requesting exemption and who is acting within the respective scope of practice)

Employee Name

Medical Certification for COVID-19 Vaccine Exception:

Dear Medical Provider:

Long-Term Care Facility employees are required to be fully vaccinated against COVID-19 pursuant to Executive Order of the President of the United States and CMS requirements. The individual named above is seeking a medical exemption to the requirement for COVID-19 vaccination or a delay because of a temporary condition or medical circumstance. Please complete this form if you believe that the employee's clinical condition meets the guidelines for an approved exemption or delay.

In the box below please provide the description of the medical condition for which the employee listed above should be exempted from complying with the COVID-19 vaccination requirements. Provide the following information, where applicable:

1. The applicable contraindication or precaution for COVID-19 vaccination, and for each contraindication or precaution, 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; (please indicate which vaccines are contraindicated for the individual and the recognized reason for the contraindication) and
2. A statement that the individual's condition and medical circumstances relating to the individual are such that COVID-19 vaccination is not considered safe, indicating the specific nature of the medical condition or circumstances that contraindicate immunization with a COVID-19 vaccine or might increase the risk for a serious adverse reaction

Description:

The condition described above is:	☐ temporary ☐ 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**