Wellstar Employee Health

Request for Medical Exemption from the COVID-19 Vaccination Requirement

SPECIAL NOTE: REVIEW OF MEDICAL EXEMPTION REQUEST FORMS WILL BE REVIEWED IN THE ORDER IN WHICH THEY ARE RECEIVED.

Basic Information (required):

Name: _____ Date: _____

I am □ Employee □ Non-employed Provider □ Student □ Vendor □ Volunteer

Department: _____ Title: _____

Immediate Supervisor: _____ Supervisor Phone#: _____

Phone Number: _____ Email: _____

Mailing Address: _____

_____ _____ _____

City *State* *Zip Code*

Physician Name: _____

Physician Phone No.: _____

Physician Address: _____

1. Have you previously requested and/or been granted a medical exemption for mandatory vaccination from Wellstar Health System? Yes_____ No_____ If yes, please explain the circumstances of that request:

FOR THE LICENSED PHYSICIAN

Dear Physician:

A mandatory COVID-19 vaccination policy is in effect across the Wellstar Health System. The abovenamed individual is requesting an exception from this vaccination requirement. A medical exception from COVID-19 vaccination is allowed for certain recognized contraindications: https://www.cdc.gov/vaccines/covid-19/info-by-product/index.html

Please complete the form below. Should you have any questions, please contact Wellstar Health System Employee Health Department at (470) 793-7222.

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

□ severe allergic reaction (e.g., anaphylaxis) requiring medical intervention after a previous dose or to a component of the COVID-19 vaccine.

□ immediate allergic reaction (e.g., anaphylaxis) requiring medical intervention to a previous dose or known (diagnosed) allergy to a component of the vaccine.

Vaccine Ingredients: https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19vaccines-us.html#Appendix-C

Which ingredient caused an allergic reaction? _____

What was the reaction? _____

Which brand(s) of the COVID-19 vaccine is contraindicated?

_____

How long will the medical contraindication last? Please specify date: _____

Has the patient seen an Allergist? _____

□ The physical condition of the person or medical circumstances relating to the person are such that immunization is not currently considered safe. Please attach a separate statement that describes the medical reason justifying an exception in detail, indicating the specific nature and probably duration of the medical condition or circumstances that contraindicates immunization with the COVID-19 vaccine.

You may email this form directly to the Wellstar Employee Health Services department at **COVID_forms@wellstar.org** or return the form to the patient for submission.

I certify that _____ has the above contraindications(s) and request a medical exception from the COVID-19 vaccination.

Physician Signature: _____
NOTE: SIGNATURE STAMP NOT ACCEPTED

Date: ___/____/____ License No: _____ State or Country _____

FOR THE REQUESTER (Employee/Non-employed Provider/Student/Vendor/Volunteer)

I attest that the above information is complete and accurate to the best of my knowledge, and I understand that any intentional misrepresentation contained in this request could result in progressive disciplinary action, up to and including suspension and termination for employees and a loss of access for non-employed credentialed providers, contractors, students, vendors, and volunteers. I also understand that my request for an exception may not be granted if it creates an undue hardship for Wellstar Health System.

Signature: _____ Date: _____

Name (please print):

_____

Employee/Badge #:

_____

Summary of Next Steps

a. You will be notified of the decision regarding your requested Medical Exemption.
b. If you are granted a medical exemption, unless Wellstar Health System approves an alternative arrangement, you will be required to undergo regular COVID-19 testing (the frequency of the testing will be determined by Wellstar) in addition to observing all COVID-19 health and safety protocols.

All Covid Exemption Form Requests must be sent via EMAIL to: COVID_forms@wellstar.org

DESIGNATED OFFICE USE ONLY:

Medical Exemption Approved on: ___/___/___ Staff Signature: _____

Medical Exemption Denied on: ___/___/___ Staff Signature: _____

Wellstar Employee Health

Request for Religious Exemption from the COVID-19 Vaccination Requirement

SPECIAL NOTE: REVIEW OF RELIGOIUS EXEMPTION REQUEST FORMS ARE CONSIDERED ON A CASE-BY-CASE BASIS AND WILL BE REVIEWED IN THE ORDER IN WHICH THEY ARE RECEIVED

In accordance with federal and state laws that allow exemptions to vaccination for religious reasons, if your religious beliefs or practices conflict with Wellstar COVID-19 vaccination requirements, please provide the information below.

Basic Information (required):

Name: _____ Date: _____

I am □ Employee □ Non-employed Provider □ Student □ Vendor □ Volunteer

For Employees (required):

Department: _____ Title: _____

Immediate Supervisor: _____ Supervisor Phone#: _____

Contact Information (required):

Phone Number: _____ Email: _____

Mailing Address: _____

_____ _____ _____

City *State* *Zip Code*

Please read the below and mark "Acknowledged" by initialing each statement to signify that you have read and understand that statement:

Wellstar Health System requires employees to receive the COVID-19 vaccine to prevent COVID-19 and its complications, including death. **Acknowledged** _____

Due to my occupation, work location or duties, I may transmit COVID-19 to my patients and other healthcare workers as well as to my family and friends, even though I have no symptoms. **Acknowledged** _____

If I become infected with COVID-19, even when I have no symptoms or when my symptoms are mild, I can spread severe illness to others, particularly to those in workplace that are high risk for COVID-19 complications. **Acknowledged** _____

I have received education about the effectiveness of COVID-19 vaccinations, as well as possible adverse events. **Acknowledged** _____

I cannot get COVID-19 from the COVID-19 Vaccine. **Acknowledged** _____

I acknowledge my responsibility to uphold Wellstar Health System's Core Values and only request a religious exemption if truly necessary and in line with my sincerely held religious belief, practice, or observance. **Acknowledged** _____

Though I have been given the opportunity to be immunized with the COVID-19 vaccine at no charge to myself, I am requesting a religious exemption from taking the COVID-19 vaccine. **Acknowledged** _____

Do you provide direct patient care? (Please select a response): Yes _____ No_____

Has Wellstar Health System granted you an exemption from any other mandatory vaccine requirement in the past? Yes _____ No_____

If yes, please explain the circumstances of that request:

1. In your own words, please provide a statement, explaining why you are seeking an exemption and why the COVID-19 immunization requirement is contrary to your sincerely held religious practice and/or belief.

2. Please indicate whether you are opposed to all immunizations, and if not, the religious basis on which you object to COVID-19 immunization.

3. In some cases, Wellstar Health System will need additional information and/or documentation about your religious practice(s), belief(s), or observance(s). As such, please provide the name and contact information of your spiritual leader (if applicable).

1. Verification and Accuracy
    a. I verify that the above information is complete and accurate to the best of my knowledge, and I understand that any intentional misrepresentation contained in this request may result in corrective action, up to and including employment termination.
    Acknowledged _____
    b. My request for an exemption from the COVID-19 vaccination requirement is based upon my sincerely held religious practice and/or belief.
    Acknowledged _____
    c. I understand that my request for an exemption may not be granted if it is not reasonable, creates undue risk to patient safety or if it creates an undue hardship on my employer.
    Acknowledged _____

Date: _____

Print Name: _____

Signature: _____

Employee/Badge #: _____

Summary of Next Steps

a. You will be notified of the decision regarding your requested religious exemption.
b. If you are granted a religious exemption, unless Wellstar Health System approves an alternative arrangement, you will be required to undergo regular COVID-19 testing (the frequency of the testing will be determined by Wellstar) in addition to observing all COVID-19 health and safety protocols.

All Covid Exemption Form Requests must be sent via EMAIL to: COVID_forms@wellstar.org

DESIGNATED OFFICE USE ONLY:		
Religious Exemption Approved on:	___/___/___	Staff Signature: _____
Religious Exemption Denied on:	___/___/___	Staff Signature: _____

Wellstar Employee Health

Request for Temporary Pregnancy Exemption from the COVID-19 Vaccination Requirement

Please read the below and mark "Acknowledged" by initialing each statement to signify that you have read and understand that statement:

Wellstar Health System requires employees to receive the COVID-19 vaccine to prevent COVID-19 and its complications, including death. **Acknowledged** _____

Due to my occupation, work location or duties, I may transmit COVID-19 to my patients and other healthcare workers as well as to my family and friends, even though I have no symptoms. **Acknowledged** _____

If I become infected with COVID-19, even when I have no symptoms or when my symptoms are mild, I can spread severe illness to others, particularly to those in workplace that are high risk for COVID-19 complications. **Acknowledged** _____

I have received education about the effectiveness of COVID-19 vaccinations, as well as possible adverse events. **Acknowledged** _____

I cannot get COVID-19 from the COVID-19 Vaccine. **Acknowledged** _____

I understand that infection with COVID-19 during pregnancy pose significant risks to myself and my fetus and that the COVID-19 vaccine reduces those risk. **Acknowledged** _____

I understand that scientific evidence shows that receiving the COVID-19 vaccine during pregnancy is safe and reduces the risks associated with becoming infected with COVID-19 during pregnancy. **Acknowledged** _____

I acknowledge my responsibility to uphold Wellstar Health System's Core Values and only request a **temporary** exemption if truly necessary. **Acknowledged** _____

Though I have been given the opportunity to be immunized with the COVID-19 vaccine at no charge to myself, I am requesting a **temporary** exemption from taking the COVID-19 vaccine.
Acknowledged _____

Do you provide direct patient care? (Please select a response): Yes _____ No_____

Has Wellstar Health System granted you an exemption from any other mandatory vaccine requirement in the past? Yes _____ No_____

Please provide the end date for your request for Temporary Pregnancy Exemption. _____/_____/_____

Please explain why you believe you need a temporary exemption from the COVID-19 vaccine requirement:

_____

_____

Please attach the documentation supporting your need for a temporary exemption. If approved, you will be expected to get a COVID-19 vaccine once the temporary period ends. The end date is at the discretion of Wellstar Health System.

I understand that my request for an exemption may not be granted if it is not reasonable, creates undue risk to patient safety or if it creates an undue hardship on my employer. Acknowledged _____

Date: _____

Print Name:

_____

Signature:

_____

Employee/Badge #:

_____

Summary of Next Steps

a. You will be notified of the decision regarding your requested Temporary exemption.
b. If you are granted a religious exemption, unless Wellstar Health System approves an alternative arrangement, you will be required to undergo regular COVID-19 testing (the frequency of the testing will be determined by Wellstar) in addition to observing all COVID-19 health and safety protocols.

All Covid Exemption Form Requests must be sent via EMAIL to: COVID_forms@wellstar.org

DESIGNATED OFFICE USE ONLY:	
Temporary Approved on: ___/___/___Through: ___/___/___	Staff Signature: _____
Temporary Medical Exemption Denied on: ___/___/___	Staff Signature: _____