COVENANT HealthCare

Extraordinary care for every generation.

REQUEST FOR MEDICAL ACCOMMODATION: COVID-19 VACCINE

Complete this form if you are requesting an accommodation under the Covid-19 Vaccine & Immunization of Staff Policy. Supporting documentation and additional information may be required for any request for accommodation. This form is compliant with 42 CFR 482.42(g).

Employee instructions

Employees requesting an accommodation (herein referred to as "an exemption") from the requirement that they be vaccinated against COVID-19 for a medical reason(s) must complete this form and have a Michigan licensed MD, DO, PA-C, or NP complete the Licensed Health Care Provider section.

Health care provider instructions

Completely fill out the Licensed Health Care Provider Section including the Health Care Provider Acknowledgment with your signature and date.

Employee to complete:

Print (*Required fields)

Employee Name*: _____**E #:**_____
Date of Birth*: _____
Department: _____
Position: _____
Manager: _____
Request Date: _____

I believe I have a medical condition which prevents me from receiving the COVID-19 vaccine.

1. I authorize my health care provider to release or disclose health information about me to my employer, Covenant HealthCare.

2. Description of Health Information: The information I authorize to be disclosed is medical documentation and information my health care provider believes is related to my request for an exemption to a required vaccine(s).

3. Specific Purpose for this Disclosure: To enable Covenant HealthCare to evaluate my exemption request and possible reasonable accommodations.

4. Direction to Physician Regarding Genetic Information: Do not provide any patient or patient family member genetic information when providing health information, except where permitted by law.

5. Acknowledgements: I acknowledge and understand the following:

    a. I am not required to sign this form in order to receive health care treatment.

    b. I may request a copy of this authorization.

c. I may revoke this authorization at any time by sending written revocation to my health care provider.

d. I authorize Covenant HealthCare to contact my health care provider to verify and/or validate the information provided in connection with my exemption request.

e. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal privacy regulations. However, I understand that other applicable state laws and protections are still available.

f. A photocopy of this authorization is as valid as the original.

Employee Signature: _____ Date: _____

_____

LICENSED HEALTH CARE PROVIDER TO COMPLETE IN ITS ENTIRETY:

The person above has requested an exemption from the COVID-19 vaccine(s) due to a medical condition and/or disability. Provide detailed medical contraindication below.

I. **Impairment** – Does the Employee have a physical or mental impairment that substantially limits one or more major life activities or a record of such an impairment? If so, please describe:

_____
_____
_____

II. **Accommodations** – Describe any recommended accommodations and how the accommodations will allow the Employee to perform the essential functions of their job.

_____
_____
_____

III. **Vaccine Exemption**

1. Does the disability or medical condition prevent the Employee from receiving the COVID-19 vaccine from all of Janssen (Johnson & Johnson), Pfizer BioNTech, and Moderna? _____. If no, please specify which vaccine brands are precluded: _____.

If yes, please indicate the recognized clinical reasons for the contraindication or inability to receive the COVID-19 vaccine as follows:

☐ Employee has had a severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component

Or

☐ Employee has another qualifying reason for not receiving the COVID-19 vaccine, such as:

- ☐ Known severe allergic reaction (anaphylaxis) to Polyethylene Glycol or any component of the vaccine.
- ☐ Severe allergic reaction to first dose of Moderna or Pfizer vaccine or single dose of Johnson & Johnson vaccine (describe in detail below).
- ☐ Previous history of Multisystem Inflammatory Syndrome (MIS).
- ☐ Documented Myocarditis and/or Pericarditis after first dose of Pfizer or Moderna vaccine or single dose of Johnson & Johnson vaccine.
- ☐ Recently received convalescent plasma or Monoclonal/Polyclonal COVID-19 antibody treatment for COVID-19 infection. Date of treatment _____
- ☐ Other (describe in detail):

_____
_____
_____

Provide additional details below, attach additional pages if needed

_____
_____
_____

a. If yes, please describe any reasonable accommodations that may minimize the Employee's exposure to the virus in the workplace.

_____
_____
_____

IV. Time Limitation of Disabling Condition

Is Employee's need for accommodation temporary or permanent? _____

If temporary, please identify the date on which the request for accommodation expires: _____
_____

IV. Temporary Delay of Vaccine

Is Employee in need of a temporary delay of a COVID-19 vaccine for a clinically recognized reason?

If yes, please indicate the reason (such as acute illness secondary to COVID-19 or receipt of monoclonal antibodies or convalescent plasma for COVID-19):
_____
_____

Please indicate the date when Employee will be eligible for vaccination: _____

HEALTH CARE PROVIDER ACKNOWLEDGMENT (REQUIRED):

I am a medical provider licensed to practice medicine in the United States of America, State of Michigan, and the Employee referenced above is under my care and/or treatment. I will not condition any current or future treatment, payment, enrollment, or eligibility for benefits on this authorization form. By signing below, I affirm that the foregoing is true and accurate and that I recommend that the Employee be exempted from employer's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications. I understand that I might be required to submit supporting medical documentation or respond to requests for further information.

_____ _____

Licensed Health Care Provider (Printed Name) Signature

Address: _____ Date: _____

_____

****Return to Human Resources****

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