Mandatory COVID-19 Vaccination Form: Medical Waiver Request Form

COVERED INDIVIDUAL PORTION: TO BE COMPLETED BY REQUESTING COVERED INDIVIDUAL

OU Health is committed to protecting its employees, contingent workers, and the community from COVID-19. OU Health requires all covered individuals – employees, contingent workers, students, providers, volunteers, and any other persons who provides care, treatment, or services for the organization or its patients – to be vaccinated against COVID-19 unless granted a lawful exemption. A medical exemption may be granted upon receipt of a completed form (below) not more than 6 months old, signed and certified by a licensed healthcare provider, not related to the submitter, and whose specialty is appropriate to the associated condition. This form provided is to request a medical exemption. Upon receipt of the medical exemption request form, the Company will engage in the interactive process with you to determine if a reasonable accommodation can be granted or if it will be an undue hardship.

Covered Individual's Full Legal Name: _____

Please select one (and complete adjacent fields):

- ☐ **Employee**, provide ¾ ID _____ Position: _____
- ☐ **Contingent Worker**, provide Employer's Legal Name: _____
- ☐ **Student**, provide School Name: _____
- ☐ **Other**, please explain relation to OUH: _____

Medical Waiver: I _____ (Covered Individual Name), decline to receive the COVID-19 vaccination due to a current personal medical condition that results in receipt of any COVID-19 vaccination being medically contraindicated. I understand that if this waiver is approved, I may be subject to additional personal protective equipment (PPE), additional testing, and/or completion of educational requirements. By signing below and submitting the completed form, including the Provider portion, I acknowledge I am requesting an exemption from the COVID-19 vaccination requirement for medical reasons. I attest to the accuracy of this information and any information I submit through this process, including and understand that any false or incomplete information will result in disciplinary action, up to and including termination of employment for falsification of records.

_____ _____

Covered Individual Signature **Date Signed**

PROVIDER PORTION: TO BE COMPLETED BY REQUESTING INDIVIDUAL'S HEALTHCARE PROVIDER

Instructions: A licensed physician, PA, or APN acting within the scope of his/her practice in accordance with all applicable state and local laws must complete and sign this section. This Portion completed by the employee will not be accepted. Complete each Section for the request to be considered. By completing this form, you certify that different methods of vaccinating against COVID-19 have been considered, and recognized medical contraindications preclude all COVID-19 vaccinations.

_____ _____

Patient Name **Date of Birth**

Section 1 - This exemption should be (Select only one):

- ☐ Temporary, expiring on (mm/dd/yyyy): _____ (Explain Below Other Medical Circumstances – Section 2)
- ☐ Permanent
- ☐ Temporary Delay, expiring on (mm/dd/yyyy): _____ due to having recently had an acute illness secondary to COVID-19, received monoclonal antibodies for COVID-19 treatment or received convalescent plasma for COVID-19 treatment.

If Temporary Delay: Explain circumstances requiring delay and the date upon which the individual can begin vaccination.

_____

_____

_____

Indicate which of the following vaccines are contraindicated, as applicable, per category below, and identify any prior vaccine dose date where requested.

	Moderna	**Pfizer**	**J&J**
Immediate severe allergic reaction to previous dose or diagnosed allergy to vaccine component			
Severe allergic reaction/anaphylaxis after previous dose or to vaccine component, incl. Polyethylene Glycol (PEG)			
Medically contraindicated for reason other than 1 or 2, above			
Date of prior vaccine dose, if applicable.			

Section 2 - For each vaccine selected, detail all other medical circumstances preventing COVID-19 vaccine, including, as applicable to each: (1) reaction to any prior dose listed, (2) contraindication to alternative vaccines (such as the J&J vaccine, which does not contain PEG), and (3) a list of the components at issue. (Be specific & describe in detail or on additional sheet.)

_____

_____

_____

_____

_____

_____

Provider Certification: To a responsible degree of medical certainty, it is my opinion the referenced patient has the identified COVID-19 vaccination contraindication(s) andshould be exempted from the COVID-19 vaccination based on such medically recognized contraindication(s). By signing below, I affirm that I have reviewed the current CDC Contraindications and Precautions and affirm that the stated contraindication(s)/precaution(s) is enumerated by the CDC and consistent with established national standards for vaccination practices.

Name of Person Completing this Form: _____

Title of Healthcare Professional Completing this Form: _____

Name of Healthcare Provider: _____

Signature of Healthcare Provider: _____

Healthcare Provider's Practice Type/Specialty: _____

Date Signed by Healthcare Provider: _____

Healthcare Provider's Business Address: _____

Healthcare Provider's Business Telephone No.: _____

Healthcare Provider's Business Facsimile No.: _____