COVID-19 Medical Exemption Provider Letter

Part 1: To be completed by the employee

Name: _____	Date of Request: _____
Employee ID No.: _____	Position/Job Title: _____
Department: _____	Location(s): _____

UK HealthCare is committed to providing a safe, inclusive, and supportive experience for all and recognizes a medical exemption may be necessary to UK HealthCare's COVID-19 vaccination requirements. While UK HealthCare will carefully review all exemption requests, approval is not guaranteed.

This form is to be used to apply for a medical exemption under A03-125, the COVID-19 Vaccine Policy. It must be completed by a licensed provider (a MD, DO, APRN certified nurse practitioner or PA) and submitted in MyChart.

You will be notified in writing of the outcome of your request for an exemption. Please note that your request, along with this letter, may be submitted to a panel for further review, and that your participation in a discussion about your request may be required.

Part 2: To be completed by the treating provider

Your patient, _____ [insert printed name of patient], has requested a medical exemption with respect to all the authorized COVID-19 vaccinations.

Please indicate which reason(s) are contraindications to each vaccine listed below (a list of the components of each vaccine can be found at Interim Clinical Considerations for Use of COVID-19 Vaccines | CDC):

1. Pfizer-BioNTech (mRNA) for persons aged ≥12 years (30 µg dose) formulation

   ___ Severe allergic reaction[1] after a previous dose or to a component of this vaccine

   ___ Known (diagnosed) allergy to a component of this vaccine

   ___ Known (diagnosed) pericarditis or myocarditis following mRNA vaccine

   If you checked one of the options above, please detail (as applicable): (a) the circumstances of the allergic reaction or your knowledge of the diagnosed allergy, including the component(s) of

[1] For purposes of this form, "severe allergic reactions" include:
- Possible anaphylaxis, a progressive life-threatening reaction that typically includes urticaria but also with other symptoms such as wheezing, difficulty breathing, or low blood pressure (see CDC Guidance, Appendix D)
- Any angioedema affecting the airway (i.e., tongue, uvula, or larynx)
- Diffuse rash which also involves mucosal surfaces (e.g., Stevens-Johnson Syndrome)

the vaccine to which your patient is allergic, and/or (b) your knowledge of the pericarditis or myocarditis, including date of onset:

_____
_____
_____
_____
_____

2. Moderna (mRNA) for persons aged ≥18 years

___ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a component of this vaccine

___ Known (diagnosed) allergy to a component of this vaccine

___ Known (diagnosed) pericarditis or myocarditis following mRNA vaccine

If you checked one of the options above, please detail (as applicable): (a) the circumstances of the allergic reaction or your knowledge of the diagnosed allergy, including the component(s) of the vaccine to which your patient is allergic, and/or (b) your knowledge of the pericarditis or myocarditis, including date of onset:

_____
_____
_____
_____
_____

3. Janssen (viral vector) for persons aged ≥18 years

___ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a component of this vaccine

___ Known (diagnosed) allergy to a component of this vaccine

If you checked one of the options above, please detail the circumstances of the allergic reaction or your knowledge of the diagnosed allergy, including the component(s) of the vaccine to which your patient is allergic:

_____
_____
_____
_____
_____

4. Other: If you believe your patient has a disability or a medical condition that would cause you to recommend exempting them from one or more of the vaccines listed above, please explain:

_____
_____
_____

_____
_____

Is this a temporary or permanent medical condition/disability?

- ☐ Temporary and will be able to receive any vaccination(s) on _____.
- ☐ Permanent

Based on the above information, it is my recommendation that my patient be exempted from UK HealthCare's COVID-19 vaccination requirements due to the above CMS/CDC-recognized clinical contraindications and/or based on a verified disability or a medical condition.

_____ _____
Signature of Provider Date

_____
Printed name of provider

_____
Board issuing provider's license

_____
Provider's license number

_____
Provider's address and phone number