**COVID-19 Vaccine Medical Exemption Request Form**

**Employee/Student Form (Attachment A)**

**Medical Exemption Requests.** This form is used to request a medical exemption to CoxHealth’s COVID-19 vaccination requirement. Medical exemptions may be granted for recognized contraindications. Guidance about medical contraindications for COVID-19 vaccination can be obtained from the Advisory Committee on Immunization Practices (ACIP) available at h[ttps://www.cdc.gov/vaccines/covid- 19/info-by-product/clinical-considerations.html.](http://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html)

# INSTRUCTIONS

1. **Complete and sign this page (Attachment A).**
2. **Present Attachment B to your healthcare provider to complete.**
3. **Return both completed forms to:** Emily.Harrington@coxhealth.com.

After Attachment A and Attachment B are completed and submitted, they will be reviewed and CoxHealth will notify the employee/student of the decision to grant the exemption (with or without conditions), deny the exemption, or request more information. Requests for exemptions will be kept confidential and shared only with those who need to know.

# Employee/Student Name: Emp/Student ID Number: Position/Title: Department:  Work/School Email Address: Best Phone Number:

**Verification**

I request an exemption from the COVID-19 vaccine requirement for medical reasons. I understand that my request for an exemption may not be granted if it is not reasonable or if it is determined that I will present a direct safety threat to myself or others that cannot be eliminated by other means. I verify that the information I submit in support of my request for a medical exemption from the COVID-19 vaccine is complete and accurate, and I understand that any intentional misrepresentation contained in this request may result in corrective action, up to and including termination of my employment.

**Signature of Employee/Student**: **Date**:\_\_\_\_\_\_\_\_\_\_\_

 **Printed name**: \_

