ROGERS
Behavioral Health

COVID-19 Vaccination
Medical Waiver Request

Employee or Applicant or Volunteer

Instructions
1. Read, complete and sign this page.
2. Return the completed form to Employee_Health@rogersbh.org

Name: ______________________________________ **Date of Request:** ________________________

Position Title: _______________________________ **Department:** ___________________________

I understand that, consistent with Federal law, CMS in the Interim Final Rule 42 CFR § 485.725 requires all employees to be vaccinated against COVID-19 unless granted a medical or religious exemption, in order to protect myself, my family, my colleagues and our patients. I have received education and information regarding the vaccine and have had an opportunity to ask questions, and I acknowledge the following:

- COVID-19 is a serious disease that has already killed hundreds of thousands of people in the United States.
- The COVID-19 vaccination is intended to prevent or reduce the incidence of the COVID-19 disease and its complications, which may include death.
- COVID-19 vaccination is required by CMS for health care workers to protect patients from COVID-19 disease, its complications and death.
- All individuals could be exposed to the COVID-19 virus through the community and could bring the illness into the health care setting.
- If infected with COVID-19, an individual could shed the virus for several days before COVID-19 symptoms appear. Shedding the virus can spread the COVID-19 disease to patients in this facility and to colleagues and family.
- I understand that variants of the virus that causes COVID-19 infection are prevalent, which may require additional or different vaccines to be given in the future.
- If I am exempted from the vaccination mandate, I must comply with any and all alternative infection control requirements imposed as a condition of exemption and I am subject to discipline, up to and including termination, for failing to comply.

Notwithstanding the above, I am requesting an exemption from taking the COVID-19 vaccine at this time.

Clarification may be requested by Rogers Behavioral Health in writing or by phone. All requests are reviewed on a case-by-case basis.

My patient should not be vaccinated against COVID-19 for the following reason and for the time period identified below:

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If there is any additional supporting documentation please attach it to this form.

I certify that my patient has the above contraindications and request medical exemption from the COVID-19 vaccination.

Physician signature: ____ Date: ____________________

If, rather than exemption, vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment, a signed and dated statement as described above, which includes the period of exemption, is provided. When the period of exemption has passed, I will be required to obtain the vaccination and provide proof of same to the employer.

Summary of Next Steps

1. Return this form to Employee Health via fax or email: Email to Employee_Health@rogersbh.org by December 6, 2021.
2. This request will be reviewed by the Employee Health Exemption Committee.
3. Additional information and/or supporting documentation may be requested. Failure to timely provide such information and/or documentation may result in a denial of the request for exemption.
4. You will be notified of the decision regarding your requested exemption.
5. If you are granted a medical exemption, you may be required to wear a surgical mask, use other PPE and/or take other infection control precautions (such as weekly testing). Such alternative infection control requirements will be in force as long as it is deemed necessary.

I have read and fully understand the information on this request for exemption. I also understand that if my request is approved, it may be approved for this year only and that exemption for any future years may require the completion and submission of a new request form and may require the provision of additional information and/or supportive documentation. I also understand that my request for an exemption may not be granted if it is not reasonable or creates a direct threat as permitted by law. I understand and agree that the granting of exemption is not a promise of continued employment for any period of time and that if employed, I will be/remain employed at will. I certify that the above information is complete, accurate and honest.

Name (Print): ____________________________________

If employee, ID# ___________________________ Department: _____________________________

Contact Phone: _____________________________ Contact Email: ______________________________

Employee Signature: ______________________________ Date: _________________

Physician Signature _______________________________ Date __________________

Section below is to be completed by Employee Health staff.

This was reviewed by the Exemption Committee on _____________ (date) and determined that ____.

☐ *Qualifies for exemption.* ☐ *Does not qualify for exemption.*

Further actions to be taken include: ____

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The requestor was notified of the results of the review on ____________ (date) by ______________________________.