Request for Accommodation: Medical Exemption from COVID -19 Vaccination

Completing this form:

To request a medical exemption from the required COVID19 vaccinations please complete Section 1 below and have your medical provider complete Section 2 before returning this form. Upon completion please submit your completed form via email to exemption@aminj.com.

Section 1 – To Be Completed by the Employee:

Name: _____ **Date of Request:** _____

Title: _____ **Department:** _____

I verify that the information I am submitting to substantiate my request for exemption from the Atlantic Medical Imaging COVID-19 Vaccination Policy is true and accurate to the best of my knowledge. I understand that any falsified information can lead to disciplinary action, up to and including termination of employment.

I further understand that Atlantic Medical Imaging is not required to provide this exemption accommodation if doing so would pose a direct threat to myself or others in the workplace or would create an undue hardship Atlantic Medical Imaging.

Print this document and sign on the line below:

Employee signature: _____ **Date:** _____

Medical Certification for COVID-19 Vaccination Exemption

Section 2 – To be Completed by the Employees Physician

Dear Medical Provider:

Atlantic Medical Imaging requires vaccination against COVID-19 as a condition of employment. The individual named above is seeking an exemption to this policy due to medical contraindications.

Please complete this form to assist Atlantic Medical Imaging in the interactive process in determining the medical exemption from the COVID-19 Vaccine Requirement.

Guidance for Exemption:

Guidance for medical Exemptions for COVID vaccinations can be obtained from the contraindications, indications and precautions described by the most recent recommendations of the Advisory Committee on Immunizations Practices (ACIP) available in the Center for Disease Control and Prevention publication, Morbidity and Mortality Weekly Report. They can be found at the following website: https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/covid-19.html.

Contraindications that indicate when vaccines should be given. A **contraindication** is a condition that increases the change of a **serious adverse reaction**. A **precaution** is a condition that might increase the chance or severity of an adverse reaction or compromise the ability of a vaccine to produce immunity. An **indication** is a condition that increases the chance of serious complications due to COVID infection. If an individual has an indication for COVID vaccination, it is recommended that they be immunized.

These are *not* considered contraindications to COVID-19 vaccination:

- Minor acute illness (e.g., diarrhea and minor upper respiratory tract illnesses, including otitis media).
- Mild to moderate local reactions and/or low grade or moderate fever following a prior dose of the vaccine.
- Sensitivity to vaccine component (e.g., soreness, redness, itching, swelling at the injection site).
- Current antimicrobial therapy.
- Family history
- Any condition which is itself an indication for COVID vaccination.

Contraindications to all COVID vaccines include the following:

- Severe allergic reactions after a previous dose or to a vaccine component leading to anaphylaxis. *

Precautions to all COVID-19 vaccines include the following:

- History of Guillain Barré Syndrome.
- Current moderate or severe acute illness with or without fever (until symptoms have abated).

*A severe allergic reaction is characterized by a sudden or gradual onset of generalized itching or erythema (redness); hives; angioedema (swelling of the lips, face or throat); severe bronchospasm (wheezing); shortness or breath; shock; abdominal cramping; or cardiovascular collapse.

Patient Name: _____ **Patient DOB:** _____

The person named above should not receive the COVID-19 vaccine due to:
Diagnosis Date: _____ **Diagnosis Code:** _____
This exemption should be: ☐ Temporary, expiring on: __/__/____, or when _____ ☐ Permanent

Healthcare Provider Name (please print): _____

Specialty: _____

NPI Number: _____ License Number: _____

State of Licensure: _____

Address:

_____

_____

_____ _____ _____

City State Zip Code

_____ _____ _____

Phone Number Fax Number Email Address

By signing below, I affirm that I have reviewed the current ACIP Contraindications and Precautions and that stated contraindication(s)/precaution is/are enumerated by the ACIP and consistent with established national standards for vaccination practices. I understand that I might be required to submit supporting medical documentation. I affirm that I am the treating physician, or an active member of the patients clinical care team. I also understand that any misrepresentations might result in referral to New Jersey State Board of Medical Examiners and/or appropriate licensing/regulatory agency.

I further certify the above information to be true and accurate, and request exemption from the COVID-19 vaccination for the above-named individual.

Signature: _____ Date: _____