COVID-19 Vaccine Medical Exemption Form

Marshall University Joan C. Edwards School of Medicine ("SOM") and University Physicians & Surgeons, Inc. d/b/a Marshall Health ("MH") requires that faculty, residents, fellows and students be vaccinated against coronavirus SARS-CoV-2 ("COVID-19"). A medical exemption may be granted upon receipt of the 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.

Medical exemptions expire when the medical condition(s) contraindication COVID-19 immunization changes in a manner in which permits immunization, as determined by MH in reviewing the request. The assigned expiration is at the sole determination of MH.

Individuals with an approved exemption may be required to comply with additional testing and other preventative requirements. In the event of an outbreak on or near MH facilities, individuals holding exemptions may be excluded from all facilities and activities, for their protection, until the outbreak is declared to be over.

The Division of Occupational Health, along with the SOM/MH Human Resources and the Marshall Health's Executive Management Team will carefully review all requests. After your request has been reviewed and processed, you will be notified in writing, if an exemption has been granted or denied. If the approval exemption contains an expiration, you will be expected to the complete the requirement at that time. Should the condition continue, or a new immunization contraindication occur, a new request with updated documentation is required. The decisions of the committee are final and not subject to appeal. Individuals whose requests have been denied are permitted to reapply if new documentation and information should become available.

In order to submit a request, please:

- **Read the CDC COVID-19 Vaccine Information, *https://www.cdc.gov/coronavirus/2019-ncov/vaccines/index.html***
- **Complete this form**
- **Have your provider complete the provider section of this form**
- **Attach all supplemental materials**
- **Return the completed documents to occupational health:**
  Georgetta Ellis, Clinical Coordinator
  Division of Occupational Health
  Marshall Health
  1600 Medical Center Drive
  Huntington, WV 25701

  or

  Email to Georgetta Ellis at ellisg@marshall.edu

Note: incomplete submissions will not be reviewed. Be sure all forms and documentation are submitted at one time.

Initial next to each of the statements below:

_____I request exemption for the COVID-19 immunization requirements due to my current medical condition.

_____I understand and assume the risks of non-immunization. I accept full responsibility for my health, thus removing liability from Marshall Health to the required immunization.

_____I understand that as I am not vaccinated, in order to protect my health and the health of the community, I will comply with assigned COVID-19 testing requirements and other preventative guidance.

_____I understand that in the event of an outbreak or threatened outbreak, I may be temporarily excluded or reassigned from Marshall Health facilities and activities. I agree to comply with these restrictions and accept responsibility for communicating with supervisors, human resources or my department administrator as appropriate.

_____Should I contract COVID-19, I will immediately report it to Marshall Health Occupational Health and comply with all isolation and quarantine procedures specified by Marshall Health.

_____I acknowledge that I have read the CDC COVID-19 Vaccine Information.

_____I understand that this exemption will expire when the medical condition(s) contraindicating immunization changes in a manner which permits immunization, as determined Marshall Health in reviewing the request.

_____I understand and agree to comply with and abide by all Marshall Health policies and procedures.

_____I understand that this exemption is only valid for the approved period and I may need to submit a new request for any subsequent changes, new medical contraindications, or on expiration of an approved exemption.

_____I certify that the information I have provided in connection with this request is accurate and complete. I understand that this exemption may be revoked and I may be subject to disciplinary action if any of the information I provided in support of this exemption is false.

Print name:_____

Signature:_____Date:_____

Email:_____Phone number:_____

- - - - - - - - - - -**THE FOLLOWING SECTION SHOULD BE COMPLETED BY A MEDICAL PROVIDER**- - - - - - - - - - -

Request for COVID-19 Medical Immunization Exemption

This section should be completed by a medical provider. Please answer the following questions to help us understand the reasons for requesting a medical exemption to the COVID-19 vaccines.

1. Patient's first and last name:_____
2. Does the patient have a documented severe, life-threatening allergic reaction (anaphylaxis requiring epinephrine), or immediate systemic allergic reaction (within 4 hours of receipt) to all of the FDA authorized COVID-19 vaccines or a component of each of them? *https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html#Appendix-c*
   ❑ Yes ❑ No
   If yes, please indicate the vaccine type or the component to which the allergy has been documented:
   _____
   _____
   If yes, please indicate the type of allergy experienced:_____
   _____
3. Does the patient have a reason to defer vaccination due to any of the following medical reasons?
   a. Patient is currently pregnant, and does not want to receive any of the COVID-19 vaccines until their pregnancy is complete (note that this is not a contraindication to vaccination, but we are allowing individual discretion. COVID-19 vaccination of pregnant women is recommended by the CDC. *https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html#Pregnant)*.
   ❑ Yes ❑ No If yes, estimated due date:_____

   Patient is currently breastfeeding, and does not want to receive any of the COVID-19 vaccines until they are no longer breastfeeding (note that this Is not a contraindication to vaccination but we are allowing individual discretion. COVID-19 vaccination of breastfeeding women is recommended by the CDC. *https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html#Pregnant)*.
   ❑ Yes ❑ No If yes, estimated breastfeeding end date:_____
   If yes, I have discussed with my patient that they have a duty to update this exemption request when the patient is no longer breastfeeding.
   ❑ Yes ❑ No

   Patient has undergone hematopoietic or solid organ transplant within the past 3-6 months.
   ❑ Yes ❑ No
   If yes, date of transplant:_____
   If yes, end date of requested exemption (must be within 3-6 months of transplant:_____

   d. Patient has been treated with rituximab within the past 3-6 months.
   ❑ Yes ❑ No
   If yes, date of receipt of this mediation:_____
   If yes, end date of requested exemption (must be within 3-6 months of last dose of rituximab:_____

   e. Patient has received COVID-specific monoclonal antibodies in the past 90 days (with provider documentation).
   ❑ Yes ❑ No
   If yes, name of the medication:_____
   If yes, date of receipt of this medication:_____
   If yes, end date of requested exemptions (must be within 90 days of receipt):_____
4. Provider name:_____
5. Provider NPI:_____
6. Provider specialty:_____
7. Provider employer/affiliation:_____

Provider signature: _____ Date: _____