

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

appropriate.

- 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: in	complete submissions will not be reviewed. Be sure all forms and documentation are submitted at one time.
Initial n	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

I acknowledge that I have read the CDC COVID-19 VaccineI understand that this exemption will expire when the med changes in a manner which permits immunization, as deteI understand and agree to comply with and abide by all Ma	dical condition(s) contraindicating immunization	
changes in a manner which permits immunization, as dete		
I understand and agree to comply with and abide by all Ma	· .	
	arshall 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 understand that this exemption may be revoked and I may information I provided in support of this exemption is false	be subject to disciplinary action if any of the	
Print name:		
Signature:	Date:	
Email:	Phone number:	

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? httml#Appendix-c httml#Appendix-c https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html#Appendix-c https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html#Appendix-c https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html https://www.cdc.gov/vaccines-us.html https://www.cdc.gov/vaccines-us.html https://www.cdc.gov/vaccines-us.html https://www.cdc.gov/vaccines-us.html https://www.cdc.gov/vaccines-us.html https://www.cdc.gov/vaccines-us.html <a< th=""></a<>
	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). \[\textstyle{\textstyle
	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):
5. 6.	Provider name:
	ovider signature: Date: