Request for Medical Vaccination Exemption

ALL sections of the form must be completed, including provider explanation and signature.

Name ____________________ Date __________

If you are an ACOM student please indicate your year: ☐ OMS I ☐ OMS II ☐ OMS III ☐ OMS IV ☐ Fellow

Email ____________________ Department / Division ____________________

Phone Number __________ Employee / Student Number __________ Job Title *(does not apply if you are an ACOM student)* __________

Explain in your own words why you are requesting this exemption.

☐ Flu Exemption

☐ Other ____________________

Provide the attached correspondence to your medical provider and return with your exemption request.

I hereby affirm the truthfulness of this statement.

SIGN HERE ____________________ Signature __________ Date

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Dear Medical Provider,

The individual named here is seeking an exemption to this policy due to medical contraindications. Medical contraindications and precautions for immunization should be based on the most recent recommendations of the Advisory Committee on Immunization Practices/CDC.

Please complete this form to assist Southeast Health in the reasonable accommodation process.

It is my medical opinion that ______________________________ **should not receive**
(patient name)

the ____ **due to:**
(insert any and all specific vaccinations by name)

_______ Severe allergic reaction (e.g. anaphylaxis) after a previous dose or close to a vaccine component. Please provide the dates of allergy testing and the results of such testing:

_______ Other (explain, attach additional sheets as necessary):

This exemption should be:

☐ Temporary, expiring on: __/__/____, or when ______________________________

☐ Permanent

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

____
Medical Provider Name (print):

______________________________ ______________
Medical Provider Signature: Date

______________________________ ______________
Practice Name Provider Phone

____
Practice Address, City, State, & Zip