

## **COVID-19 Vaccination Exemption Medical Provider Statement**

Section I: Contact Information. Complete before submitting to your medical provider.

Name:	Please select status:
UTHealth ID (school or work):	Employee
Phone:	Resident/Fellow
Email:	□ Student
Job Title:	New Hire (has not started work at UTHealth)
Primary school affiliation or work location:	Visiting Scholars Program Participant
-	Adjunct Faculty
HCPC Unit/Work Location:	□ Volunteers
	Contractor (if selected, provide employer information)
	Employer:
	Job Title:

Section II: Medical Provider Contraindication Statement. This section must be completed by a licensed physician, physician's assistant, or nurse practitioner operating within their respective scope of practice. Self-certified Medical Provider Statements will not be accepted.

Guidance for the medical exemptions for COVID-19 vaccination can be obtained from the Advisory Committee on Immunization Practices (ACIP), available at <u>https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html</u>.

By completing this Section II, I certify that my patient, the individual stated above, has a physical condition and/or medical circumstance, and because of the physical condition and/or medical circumstances, the vaccinations currently authorized by the FDA for COVID-19 are not considered safe for administration to this individual at this time for the reasons indicated below. I understand and have counseled my patient that not receiving this vaccination does increase risk for disease(s). I further certify that:

- I am not the individual requesting the exemption.
- I am acting within my respective scope of practice based on applicable state and local laws.
- I recommend the individual named above be exempted from COVID-19 vaccinations.
- All of the information provided by me on this form is true and correct to the best of my professional medical knowledge and opinion.

Please provide the physical condition and/or medical circumstance indicated and which prevent COVID-19 vaccination at this time:

## If applicable, you must select the medically-indicated contraindication for each vaccine (each column must be checked at least once for your patient to qualify for a medical exemption):

	Johnson & Johnson (Janssen)	Moderna ("Spikevax")	Pfizer-BioNTech ("Comirnaty")
<ol> <li>Severe allergic reaction (anaphylaxis) after a previous dose of or to a component of the COVID-19 Vaccine, including polyethylene glycol (PEG)</li> </ol>	□ (Please note that the Janssen vaccine does not contain PEG)		
<ol> <li>Immediate allergic reaction to a previous dose or known diagnosed allergy to a component of the vaccine.</li> </ol>			

Signature of Health Care Provider

Health Care Provider's Printed Name

Type of Practice/Medical Specialty:	Date:
Provider's Business Address:	
Telephone:	Fax:
Provider E-mail:	

Section III: Medical Provider Vaccination Delay Statement. This section must be completed by a licensed physician, physician's assistant, or nurse practitioner operating within their respective scope of practice. Self-certified Medical Provider Statements will not be accepted.

Guidance for medical exemption delay considerations can be obtained from the ACIP, available at <u>https://www.cdc.gov/vaccines/covid-19/downloads/summary-interim-clinical-considerations.pdf</u>.

By completing this Section III, I certify that the COVID-19 vaccination of my patient, the individual stated above, should be temporarily delayed as recommended by the CDC due to a physical condition and/or medical circumstance. My patient may begin vaccination on the following date:

Signature of Health Care Provider

Health Care Provider's Printed Name

Type of Practice/Medical Specialty:	Date:
Provider's Business Address:	
Telephone:	Fax:
Provider E-mail:	

Completed forms should be submitted to Diversity and Equal Opportunity Office at CALL@uth.tmc.edu.