Medical Certification for COVID-19 Vaccination Exemption

Co-Worker/Patient Name: _____

Date of Birth: _____

Dear Medical Provider:

Mercy 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 Mercy in the reasonable accommodation process.

NOTE: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers from obtaining genetic information as to any employee or family member except as specifically allowed by this law. To comply with this law, ***we are asking that you not provide any genetic information when responding to this request for medical information.*** "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family members receiving assistive reproductive services.

The person named above should not receive the COVID-19 vaccine due to:

_____

_____

_____

_____

This exemption should be:

- ☐ Temporary, expiring on: __/__/____, or when _____
- ☐ Permanent

This exemption applies to the: ❒Pfizer-BioNTech Vaccine ❒ModernaTX, Inc. Vaccine ❒Johnson & Johnson vaccine (check all that apply)

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

Medical Provider Name (print):	
Medical Provider Signature:	Date:
Practice Name & Address:	Provider Phone:

Request for Religious Exemption from COVID-19 Vaccination

Religious Leader / Attestor Certification Form

Co-worker Name: _____

Mercy is committed to protecting its patients, co-workers, physicians, volunteers, and the public from COVID-19 and, thus, requires all co-workers to receive the COVID-19 vaccination. A religious exemption may be granted to accommodate sincerely held religious beliefs that prohibit an individual from obtaining the COVID-19 vaccination. The individual identified above is requesting a religious exemption from this vaccination. Your supporting statements will assist us in evaluating this request. Please complete the information below for the above-named individual.

I CERTIFY that the above-named individual has the following sincerely held religious beliefs requiring exemption from the COVID-19 vaccination (attach additional pages if necessary):

_____

_____

_____

Church or Religious Body: _____

Actions other than refusal to obtain vaccinations that demonstrate the above-named individuals sincerely held religious objection to the COVID-19 vaccination:

_____

_____

I AUTHORIZE Mercy to contact me directly for additional information and/or clarification about my knowledge of the above-named individual's religious beliefs and objections to the COVID-19 vaccination.

Print Name: _____

Signature: _____

Date:_____ Phone Number: _____

Request for Medical Exemption from Seasonal Influenza Vaccination

PROVIDER CERTIFICATION – To be completed by the requestor's personal healthcare provider.

Patient Name: Date of Birth:

Dear Provider:

As a safety initiative, Mercy requires its co-workers and physicians to receive an annual influenza vaccine. The influenza vaccination is recommended for healthcare workers to help reduce the incidence of influenza in inpatient populations and other at-risk individuals. Influenza vaccination has also been recommended in pregnancy by the Centers for Disease Control to protect pregnant women (who are at increased risk of severe disease) and to protect the baby after it is born. Your patient is requesting a medical exemption from this vaccination requirement. Medical exemptions are granted only for certain recognized contraindications. Medical exemption decisions will be made based on the recommendations from the CDC, AAAAI and ACIP.

Please explain why your patient should not receive the influenza vaccine:

☐ Previous reaction to influenza vaccine (e.g. hives, difficulty breathing, swelling of tongue or lips)

- The above does **not** include sensitivity to the vaccine such as an upset stomach or mild to moderate local reactions such as soreness, redness, itching, or swelling at the injection site.
- The above does **not** include subsequent upper respiratory infection or low-grade or moderate fever following a prior dose of the vaccine.

Description of Reaction:

_____

_____

_____

Date of Reaction: _____

☐ History of Guillain Barré Syndrome

Description Event:

_____

_____

_____

Date Patient had GBS: _____

☐ Other

Description:

_____

_____

_____

Date of Reaction/Event: _____

I CERTIFY that my patient has the contraindication as identified above and request that he/she be considered for a medical exemption from the influenza vaccination.

Provider Name (PRINT): _____

Address:_____ Phone: _____

Provider Signature: _____ Date: _____

****** Important Warning:*** *The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information" as defined by GINA, includes the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.*

Request for Religious Exemption from Seasonal Influenza Vaccination
Religious Leader / Attestor Certification Form

Co-worker Name: _____

Mercy is committed to protecting its patients, co-workers, physicians, volunteers, and the public from the flu and, thus, requires all co-workers to receive an influenza vaccination. As a healthcare organization, Patient Safety is a core value. Although not perfect, the influenza vaccination is the most effective way to prevent transmission of flu to patients and others. A religious exemption may be granted to accommodate sincerely held religious beliefs that prohibit an individual from obtaining the influenza vaccination. The individual identified above is requesting a religious exemption from this vaccination. Your supporting statements will assist us in evaluating this request. Please complete the information below for the above-named individual.

I CERTIFY that the above-named individual has the following sincerely held religious beliefs requiring exemption from the influenza vaccination (attach additional pages if necessary):

_____

_____

_____

Church or Religious Body: _____

Actions other than refusal to obtain vaccinations that demonstrate the above-named individuals sincerely held religious objection to the influenza vaccination:

_____

_____

I AUTHORIZE Mercy to contact me directly for additional information and/or clarification about my knowledge of the above-named individual's religious beliefs and objections to the influenza vaccination.

Print Name: _____

Signature: _____

Date: _____ Phone Number: _____