POMONA VALLEY HOSPITAL
MEDICAL CENTER

Medical Verification of Request for Exemption for Qualifying Medical Reasons from COVID-19 Vaccination

Associate Name (PRINT):_____ Associate ID #: _____

Department:_____ Associate Phone #: _____

Email Address: _____

I request that I be exempted from the COVID-19 vaccination requirement based on qualifying medical reasons, per the most up-to-date COVID-19 vaccine guidelines from the Centers for Disease Control and Prevention (CDC). My request is supported by the certification of my health care provider who I have, and do, authorized to release medical information concerning me, as it relates to this request.

_____ _____

Associate Signature **Date**

Please have your physician, nurse practitioner or other licensed medical professional practicing under the license of a physician, complete this form. Do not submit any information that identifies your diagnosis, disability, genetic information or other medical information unrelated to your request for exemption. Self-completed forms will not be accepted.

Dear Medical Professional:

The individual identified above works/volunteers at Pomona Valley Hospital Medical Center (PVHMC) and is requesting to be exempt from the COVID-19 vaccination requirement. COVID-19 vaccination is generally recommended as an effective means in reducing infection and serious disease. Furthermore, the California Department of Public Health issued an order on August 5, 2021, which requires all workers and volunteers who work at or for PVHMC to be vaccinated for COVID-19, unless there is an exemption for qualifying medical reasons or religious reasons.

Please complete the information below if you support your patient's request for medical exemption for qualifying medical reasons, per the most up-to-date COVID-19 vaccine guidelines from the CDC. ***Do not provide any information that identifies this individual's diagnosis, disability, or genetic information.*** Should you have any questions, please call Occupational Health Services at 909.865.9501, ext. 1035.

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 an individual's family medical history, the results of 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.

My patient should not be vaccinated against COVID-19 for the following qualifying medical reason (please mark applicable box):

☐ **Temporary exemption**: The requirement that the individual identified above be vaccinated should be deferred due to a limited term inability to receive the COVID-19 vaccination (such as due to receipt of monoclonal antibodies or convalescent plasma for the treatment of COVID-19 in the last 90 days).

Expiration of deferment: _____

☐ **Permanent exemption**: The individual identified above should be excused from the vaccination requirement for the following reason, per the most up-to-date COVID-19 vaccine guidelines from the Centers for Disease Control and Prevention (CDC):

☐ History of allergy to vaccine component (does not include sore arm, fatigue, local reaction or subsequent respiratory tract infection)

☐ Other (describe in space below and provide supporting documentation)

_____

_____

_____

_____

_____

I certify that the individual has the above contraindication and requests medical exemption from the COVID-19 vaccination. I understand I may be contacted by Pomona Valley Hospital Medical Center's Occupational Health Services for further explanation.

Medical Provider Signature:_____ Date: _____
(Signature stamps will not be accepted)

Medical Provider Name: (Please Print)_____Medical Provider Phone #: _____

Medical Provider Address: _____

License Number: _____

If practicing under the license of a physician, name and license number of physician:
_____

_____

Medical Panel Review: ____Approved ____Not Approved

Panel Chairperson: _____ **Date**: _____