



To be Completed by the Medical Provider

Individual's Name

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Medical Certification for COVID-19 Vaccine Exception

Dear Medical Provider:

The individual named above is seeking a medical exception to the requirement for COVID-19 vaccination or a delay because of a temporary condition or medical circumstance. Please complete this form to assist in a reasonable accommodation process. If you have questions about completing this form, please contact Indiana Regional Medical Center's Employee Health Department at 724-357-7051.

Please provide at least the following information, where applicable:

1. The applicable contraindication or precaution for COVID-19 vaccination, and for each contraindication or precaution, indicate: (a) whether it is recognized by the CDC pursuant to its guidance; and (b) whether it is listed in the package insert or Emergency Use Authorization factsheet for each of the COVID-19 vaccines authorized or approved for use in the United States;
2. A statement that the individual's condition and medical circumstances relating to the individual are such that COVID-19 vaccination is not considered safe, indicating the specific nature of the medical condition or circumstances that contraindicate immunization with a COVID-19 vaccine or might increase the risk for a serious adverse reaction; and
3. Any other medical condition that would limit the employee from receiving any COVID-19 vaccine.

Description of the medical condition for which the employee listed above should be excepted from complying with a COVID-19 vaccination requirement:

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The condition described above is:

temporary

long-term

If this is a temporary condition or medical circumstance, when it is expected to end or expire (allowing for COVID-19 vaccination to begin after the date you provided):

Medical Provider Name/Title

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Medical Provider Signature

Date

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IRMC

Disposition Date: _____

Approved Denied Request Further Information

Comments _____

