**Please circle:** Brandywine Hospital; Chestnut Hill Hospital; Jennersville Hospital; Phoenixville Hospital; Pottstown Hospital; Reading Hospital; Tower Health Medical Group/Location \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_; Tower Health Urgent Care/Location ; Tower Health at Home; Tower Health Partners; Tower Health PPO; RHSHS Student; External Student; Vendor or Representative; Consultant; Contractor; Volunteer; Other:

INSTRUCTIONS: Please read and sign Page 1, then discuss the medical issue(s) that prevent(s) you from obtaining the particular vaccine(s) with your physician or advanced practice provider. Your practitioner should then fill and sign Page 2. **It is your responsibility to provide any available documentation** from your medical record that describes your reaction or your medical condition. Submission of this form does not guarantee an exemption - it begins the exemption process.

I understand and acknowledge the following:

1. I may have a life-threatening medical reaction and I wish to apply for exemption from: (Please circle a vaccine:) Influenza COVID-19 Tdap (whooping cough) MMR (measles, mumps, German measles) Varicella (Chicken pox)
2. I understand the following:
   * Many infectious diseases are preventable. Without vaccinations men, women, and children can and do become sick and die from infectious diseases.
   * Those who work in healthcare are likely to be exposed to viruses such as influenza, mumps, measles, German measles, COVID-19 and whooping cough while at home, in the community, or at work.
   * Viral diseases can be spread to patients, colleagues, and family by workers who are infected but do not show signs or symptoms of infection.
3. Failure to submit acceptable medical documentation may result in my request being denied.
4. My personal physician cannot grant my work-related vaccine exemption. My request for a medical exemption will be researched, discussed with my doctor, and reviewed by a team of physicians. I will be contacted with a decision regarding my exemption request.
5. I may request further review if my exemption is denied.
6. My manager and/or supervisor will be notified of my exemption decision so that they can maintain a safe work environment for patients and staff. I further understand that I may need to practice additional infection prevention and control measures while at work.
7. I consent to the release of this request, including any supporting documentation, to all individuals on a need-to-know basis, so that they can carry out their duties and consider my request for an exemption.

**VERIFICATION**

I understand that if a COVID-19 vaccine exemption is approved, I will be required to undergo COVID-19 screening/testing at least weekly or more frequently as guided by policy and/or by local/county/state/federal regulations.

I hereby certify that the statements contained herein are true and correct to the best of my knowledge and belief. I understand that if I knowingly make any false statement herein, I am subject to such penalties as may be prescribed by statute or ordinance.

Last Name (Print): First Name (Print):

Signature: Date Signed:

Date of Birth:

Job or Profession:

Shift:

Department or Unit: Manager:

# (OVER)

Dear Physician or Advanced Practice Provider:

As part of the Tower Health affiliates’ commitment to the health of employees, patients, staff, and visitors, vaccines against preventable infectious diseases, including annual influenza vaccination, are required for employees and business associates at all Tower Health affiliates. The CDC, IDSA, and other professional health care and infection prevention organizations strongly recommend that health care systems require MMR, Varicella, Tdap, COVID-19 and annual influenza vaccination as an integral part of patient safety and public health. Even in years when there is not a perfect match between seasonal influenza vaccine and circulating strains, vaccination decreases the seriousness of the disease and reduces its complications.

Your patient has requested a medical exemption from one of the mandatory vaccines (see Page 1). Please complete the form below to support your patient’s request. Please note, this does not guarantee an exemption will be granted. Absence of documentation will delay or prevent consideration.

* Attach any relevant documentation to support this request.
* Provide documentation of severe reaction from the time of the actual event, if possible.
* Attach references from the medical literature supporting your opinion as you wish.

Patient Name:

DOB:

I certify that my patient has the following serious or life-threatening contraindication and request medical exemption from the vaccine(s) due to:

1. History of previous severe allergic reaction (e.g., anaphylaxis) to vaccine or its components (defined as swelling of the lips or tongue, pruritis, difficulty breathing, vomiting and diarrhea, or collapse; this does not include sore arm, large local reaction, or subsequent upper respiratory tract infection).
2. History of Guillain-Barre syndrome associated with the particular vaccine(s).
3. Other:

I understand that I may be contacted for additional supporting documentation or discussion.

Name of Physician (MD, DO) or APP (NP, PA):

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *(Signature stamps are not acceptable)*

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Forward completed form to Employee Health Services***

# FOR OFFICE USE ONLY

Received by Employee Health Services on (date):

Comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Disposition - Approved:

Denied:

Extension: expires on (date):

By: (Physician) Date: *On behalf of the reviewing healthcare team*

TH3953 9.19 (2 of 2)