Qualified Medical Exemption for COVID-19 Vaccination

As required by the California State Public Health Officer Order dated August 5, 2021, all workers who provide services or work in a hospital, clinic, or other healthcare facility, must have their first dose of a one-dose regimen series (Johnson and Johnson [J&J]/Janssen) or their second dose of a two-dose regimen (Pfizer-BioNTech or Moderna or vaccine authorized by the World Health Organization) by September 30, 2021.

Workers may be exempt from the vaccination requirements if the worker is unable to receive a COVID-19 vaccine due to Qualifying Medical Reasons. However, workers who are exempt from the vaccination requirement will instead be required to submit to COVID-19 testing either weekly or twice weekly depending on the type of facility to which the worker is assigned.

Employees wishing to claim an exemption from the COVID-19 vaccination requirement due to a Qualifying Medical Reason must submit a completed attestation (below) and medical certification (attached) that is signed by a physician, nurse practitioner, or other licensed medical professional practicing under the license of a physician, stating that the individual qualifies for the exemption by 5:00 p.m. on September 30, 2021. The completed attestation and medical certification must be uploaded using the VCHRP Employee Self Service Page.

I, _____, am requesting an exemption from
[Employee Name]
the California Department of Public Health Officer's COVID-19 vaccination requirement due to qualifying medical reasons as evidenced by the attached medical certification. Furthermore, I acknowledge that as part of my exemption from the COVID-19 vaccination, I will be required to submit to all COVID-19 testing as required by the California Department of Public Health Officer's Order.

_____ _____
Full Name (Print) Employee ID Number

_____ _____
Signature Date

MEDICAL CERTIFICATION

(To be filled out by a medical professional only)

Medical Certification for Vaccine Exemption for:

_____, date of birth ____/____/_____,
[Employee Name]

Is excused from receiving any COVID-19 vaccine because of a Qualifying Medical Reason. (Please **do not** describe the underlying medical condition.)

This exemption should be:

- ☐ Temporary, expiring on: ____/____/_____
- ☐ Permanent

By signature below, I confirm that this information is true and accurate and that I am a medical provider (MD, DO, NP, or PA) with an unrestricted license to practice in the State of California.

_____ _____
Medical Provider Signature Date

_____
Medical Provider Name

_____ _____ _____ _____ (____)_____
Office Address City State Zip Code Office Phone Number