Covid-19 Vaccination – Declination Statement

(Must accompany Medical or Religious Application for Exemption)

Please print information below:

Employee Name: _____ Personal Phone #: _____

Date of Birth: _____ Title/Position: _____

Department/Unit: _____ Manager/Supervisor: _____

Declination of Covid-19 Vaccination (Please Initial Beside Each Paragraph):

_____ I understand that due to my occupational exposure, I may be at risk of acquiring Covid- 19 infection. In addition, I may spread Covid-19 to my patients, coworkers, and/or my family, even if I have no symptoms. This can result in serious infection, particularly in persons at high risk for Covid-19 complications.

_____ I have received education about the effectiveness of the Covid-19 vaccination as well as the adverse events. I have also been given the opportunity to be vaccinated with Covid-19 vaccine at no charge to myself. However, I decline Covid-19 vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Covid-19, potentially resulting in transmission to my patients, coworkers, and/or family. If in the future I want to be vaccinated with Covid-19 vaccine, I can receive the vaccine at no charge to me.

Reason for declining:

_____ **I request a Medical application for exemption (The Request for Medical Application for exemption Form must be completed and returned to Employee Health Services (EHS).**

Employee signature: _____ **Date**: _____

PLEASE EMAIL THIS DECLINATION STATEMENT TO: JHS-Covid@jhsmiami.org

Jackson Health System –Employee Health Services
Jackson Medical Towers
1500 NW 12th Avenue Suite #1103
Miami, FL 33136

Designated For Official Use Only:

Approved on: ___/___/____ Approving Staff Signature:_____

Covid-19 Vaccination – Request for Medical Application for Exemption

Section 1. To be completed by the Employee:

Employee Name: _____ Personal Phone #: _____

Date of Birth: _____ Title/Position: _____

Department/Unit: _____ Manager/Supervisor: _____

I authorize my medical practitioner(s), any licensed physician, practitioner, hospital, clinic or medical facility to release my medical information to Jackson Health System, solely for the purpose of evaluating my request for an application for exemption from receiving the **Covid-19 vaccination**. This authorization is valid for a period one (1) year, unless revoked by me in writing to Jackson Health System. I hereby acknowledge that I am fully informed that if the necessary medical information is not released, my request for an application for exemption may be denied.

Employee Signature:_____ **Date:** _____

Section 2. To be completed by the Physician:

The above named employee is requesting an application for exemption from Jackson Health System's **Covid-19** vaccination requirement. A medical application for exemption from **Covid-19 vaccination** is allowed for certain recognized contraindications.

Please complete the form below by indicating whether a contraindication exists. Should you have any questions, please contact Employee Health Services, at (305) 585-6903, prompt 0.

Please select medically indicated contraindication below:

☐ Severe allergic reaction (anaphylaxis) after a previous dose of or to a component of the **COVID- 19** Vaccine, including Polyethylene Glycol (PEG) (Please describe response in detail below and contraindication to alternatives, such as the Johnson & Johnson vaccine, which does not contain PEG)

☐ Other medical circumstance preventing vaccination with any available COVID-19 vaccine (Be specific and describe in detail below). Please note that this will be reviewed by Employee Health Medical Director. Submission of a signed form does not guarantee an application for exemption will be granted.

I certify that _____ has the above contraindication and request that he/she be granted a medical application for exemption from *any or all* **Covid-19** vaccination.

(Note: THIS IS A MEDICAL-LEGAL DOCUMENT; NO STAMP SIGNATURE)

Physician signature:_____ Date: _____

Physician Medical License No: _____

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Medical application for exemption Approved on: ___/___ /____ Approving Staff Signature: _____