**Request for Medical Exemption from Influenza Vaccine Form**

ARH requires all employees who work within ARH to receive influenza (flu) vaccination by December 31, 2021 unless granted a legally required exemption. ARH is committed to complying with all laws protecting individuals with disabilities or medical conditions. When requested and required by law, ARH will provide an exemption/reasonable accommodation for any known medical condition or disability of a qualified individual which prevents the requestor from receiving an influenza vaccine, provided the requested accommodation is reasonable and does not create an undue hardship for ARH and/or pose a direct threat to the health or safety of others in the workplace and/or to the requesting employee.

A medical exemption may be granted upon receipt of a completed form (below) not more than 6 months old, signed and certified by a licensed health care provider, whose specialty is appropriate to the associated condition.

Medical exemptions expire when the medical condition(s) contraindicating influenza vaccination changes in a manner which permits vaccination. The assigned expiration is at the sole determination of ARH.

Individuals with an approved exemption may be required to comply with additional preventive requirements and may be updated by later notification and/or posting of requirements on the ARH website.

ARH will carefully review all requests for medical exemptions, approval is not guaranteed. After your request has been reviewed and processed, you will be notified, in writing, if an exemption has been granted or denied. If the approved exemption contains an expiration, you will be expected to complete the vaccination requirement at that time. Should the condition continue, or a new vaccination contraindication occur, a new request with updated documentation is required.

Medical exemption process:

* **Complete and electronically sign the following page of this form;**
* **Have your Licensed Health Care Provider complete the provider section of this form on Pages 3-4;**
* **Submit the completed documents.**

*Incomplete submissions will not be reviewed. Be sure all forms and documentation are submitted at one time.*

**Please initial next to each of the statements below:**

|  |  |
| --- | --- |
|   | I request exemption from the influenza vaccination requirements due to my current **medical condition**. I understand and assume the risks of non-vaccination.  |
|   | I understand that as I am not vaccinated, in order to protect my own health and the health of the community, I will comply with assigned influenza preventive guidance.  |
|   | Should I contract influenza, I will immediately report it to Human Resources and comply with all recommended isolation and quarantine procedures.  |
|   | I understand that this exemption will expire when the medical condition(s) contraindicating vaccination changes in a manner which permits vaccination, as determined by ARH in reviewing the request.  |
|   | I understand and agree to comply with and abide by all ARH’s Influenza Vaccine policies and procedures.  |
|   | I understand that, if approved, this exemption is provisional based on ARH’s current influenza vaccination policy and is subject to change based on ARH requirements moving forward. |
|   |  I authorize my licensed health care provider to provide ARH with medical information about my medical exemption for the influenza vaccination.  |
|   | I certify that the information I have provided in connection with this request is accurate and complete as of the date of this submission. I understand this exemption may be revoked and I may be subject to disciplinary action if any of the information I provided in support of this exemption is false. |
|  | I agree that I am submitting this document electronically and that it is the legal equivalent of having placed my handwritten signature on the submitted document.  |

**Attention Health Care Provider:**

ARH requires all employees who work within ARH to receive at the influenza (flu) vaccination by December 31, 2021 unless granted a legally required exemption. Your patient, \_\_\_\_\_\_\_\_\_\_\_\_\_\_, is requesting a medical exemption from this vaccination requirement. A medical exemption may be allowed for certain recognized contraindications.

Please certify below the medical reason that your patient should not be vaccinated for influenza by completing this form and attaching available supporting documentation. Information provided on this form will be reviewed in consideration of the exemption request.

**The above person should not be immunized for influenza for the following reasons (Please check all that apply.):**

**Option 1 – Allergy**

\_\_\_\_\_\_\_ A documented history of a severe allergic reaction to a previous influenza vaccination to any component of an influenza vaccine. (Note that non-anaphylactic egg allergy is a precaution for egg-based influenza vaccines, and the vaccine may still be given in a healthcare setting where the patient may be monitored appropriately. Additionally, if patient has an egg allergy, an alternative non-egg based flu vaccine may be requested.)

**Option 2 – Physical Condition/Medical Circumstance**

 The physical condition of the patient or medical circumstances relating to the individual are such that vaccination is not considered safe. Please state, with sufficient detail for independent medical review, the specific nature and probable duration of the medical condition or circumstances that contraindicate vaccination with the influenza vaccine.

Explanation:

Probable Duration:

**Option 3 - Other**

Please provide this information in a separate narrative that describes, in detail, the medical condition or disability in detail that you opine would exempt this individual from vaccination:

Explanation:

Probable Duration:

**Certification**

I certify that\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (patient name) has the above contraindication and support the request for a medical exemption from the influenza vaccine requirement at ARH.

Medical Provider Name:

Medical Provider Specialty:

Signature:

Provider License Number:

Provider Phone Number:

Patient Name:

Date:

Once you have completed this document, it must be uploaded into the Influenza Vaccine Exemption Portal Page located on ARH.org.