GRAPETREE
MEDICAL STAFFING

IMPROVING HEALTHCARE *since* 1999.

REQUEST FOR MEDICAL EXEMPTION FROM THE COVID-19 VACCINATION

Employees may apply for an exemption due to medical reasons. Medical exemption from the COVID-19 vaccination is allowed for recognized contraindications.

Employee Name: _____

Employee Signature: _____ Date: _____

Employees who have a medical condition that would prevent them from being able to receive the vaccine must present documentation from their physician/practitioner.

Please have your healthcare provider complete the information below the dotted line.

- -

HEALTHCARE PROVIDER TO COMPLETE

A licensed physician/practitioner must complete the following & sign request for exemption.

Physician/Practitioner Statement: I have reviewed the COVID-19 vaccine recommendations from the Centers for Disease Control (CDC) and request the following medical exemption based on a true medical contraindication as outlined by the CDC:

☐ **Permanent Exemption related to:**
- ☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose of COVID-19 vaccine.
- ☐ Documented history of allergy to COVID-19 ingredient: _____
- ☐ Other: _____

☐ **Temporary Exemption related to:**
- ☐ Pregnancy
- ☐ Other: _____

This individual will be able to receive vaccine on or after (date): _____

Please indicate the vaccine manufacturer(s) you are exempting employee from:

_____

Provider Name (print): _____

Address: _____ Phone Number: _____

Signature: _____ Date: _____

PLEASE EMAIL THIS COMPLETED FORM TO PROCESSING@GRAPETREE.COM.