BHS COVID-19 Vaccine Medical Accommodation Request

In compliance with the Centers for Medicare and Medicaid Services (CMS) Omnimbus COVID-19 Health Care Staff Vaccination interim final rule first published 11/5/2021, and updated per CMS Memo on 12/28/21, Butler Health System mandates vaccination against COVID-19. By federal law, employees and volunteers may request exemption from vaccination for medical/disability concerns, or for religious reasons.

If you are an employee or volunteer of BHS and believe you have a medical condition that limits or prevents you from receiving any of the currently available COVID-19 vaccines, please complete the necessary materials below. Note that you may require documentation from your healthcare provider as part of this.

Your request and all associated materials will be carefully reviewed. Additional materials may be requested, or your attesting medical provider may be contacted. Your request will be compared to appropriate federal and state regulations, and weighed against the health and safety of BHS patients and staff. You will be notified in writing of the outcome of your request.

If your exemption request is granted, it will be revisited as updated information is available, including new vaccine formulations, variant virus strains, or other factors that would impact the relative risk/benefit consideration of your exemption.

If your exemption is granted, you will need to follow standard policies for infection prevention, as well as any additional risk mitigation policies for unvaccinated staff.

Some exemptions, by definition, are simply deferments for a fixed period of time (for example, if you received anti-SARS-CoV-2 monoclonal antibody therapy). In these instances, the end date of your exemption will be documented, and you will be required to initiate your vaccine series immediately upon the completion of the approved deferral period.

Employees or volunteers may re-apply with new medical information that may impact exemption eligibility. This exemption process applies only to the COVID-19 vaccination mandate, not to any other employment requirements.

New employees or volunteers must receive notice of an approved accommodation request prior to the first day of the Junior Auxiliary Program.

If you have a medical condition that you believe limits or prevents you from complying with the COVID-19 vaccination requirement and you are requesting a medical accommodation for the vaccination requirement, please:

1. Complete Part I of the form below, including your parent's signature. Put your name on each page of packet where indicated, including Part II.
2. Unless otherwise indicated, give the packet to your medical provider. They will need to complete Part II and provide additional information to confirm your reported medical condition for exemption. (If indicated below, this step may not be needed.) Provider returns completed packet to you.
3. You must return the completed packet as soon as possible. Electronic submission is preferred (email to: VaccineAccommodationRequest@butlerhealthsystem.org) or paper requests may be submitted to BMH Employee Health or CH Human Resource office.

Request for Medical Exemption from COVID-19 Vaccine (11/15/21)

Student Name: _____

COVID-19 Vaccine Medical Exemption Request
Part I: To be completed by employee making exemption request. (Pages 2-4)

Please PRINT CLEARLY or type -- **TO BE COMPLETED BY STUDENT/PARENT**

Information on Employee Requesting Exemption	
Name	
Date of Birth	
Date of Request	
Email	
Phone Number	
Position/Title/Role	Junior Auxiliary Program
Information on Employee's Medical Provider who will Confirm Medical Exemption	
Name	
Credentials (MD, DO, etc)	
Field of Practice	
How Long Your Provider?	
Office Phone Number	
Office Fax Number	

Requirements for designated provider:

- May not be yourself or a member of your immediate family.
- Must be a licensed medical practitioner (MD, DO, CRNP, PA), whose scope of practice includes the medical condition you cite below.
- Should have a history of you as a clinical patient.

I am requesting an exemption or deferral to the BHS mandatory COVID-19 vaccination program. Please indicate the category and then the reason by checking boxes (□): **TO BE COMPLETED BY STUDENT/PARENT**

□ I am requesting a COVID-19 vaccine exemption due to a CDC-recognized contraindication to vaccination; in addition to my own description, this <u>will</u> require medical provider attestation to corroborate:

□	Severe allergic reaction within 4 hours of previous dose of COVID-19 vaccine	Describe reaction, vaccine received and date: *Severe reactions: anaphylaxis; angioedema involving airway; rash involving mucous membranes.* *NOT severe: urticaria; angioedema not involving throat or tongue.* *Note: this may not preclude receiving a different vaccine.*
□	History of allergic reaction to a component of a COVID-19 vaccine	Describe reaction AND component: *Note: individuals with PEG allergy may receive J&J; individuals with polysaccharide allergy may receive mRNA vaccine.*
□	History of myocarditis or pericarditis following COVID-19 vaccine	Describe: *Note: Myocarditis from other etiologies is <u>not</u> a contraindication to vaccination, after recovery.*
□	Multisystem inflammatory syndrome (MIS) after previous COVID-19 vaccine	Describe:
□	Thrombosis with Thrombocytopenia Syndrome after J&J vaccine	Describe: *Note: may still get mRNA vaccine.*

□ I am requesting a deferral of COVID-19 vaccination for one of the reasons below; medical provider attestation may not be required as long as employee can produce the necessary results/records:

□	Current/recent COVID-19 illness	Date of illness onset or test date: *Test results do not need to be submitted. No provider documentation required. Eligible 30 days after illness onset.*
□	Current quarantine from COVID-19 exposure	Date quarantine began: *No provider documentation required. Eligible upon completion of quarantine period.*
□	Receipt of anti-COVID monoclonal antibodies	Date of infusion: *No provider documentation required. Eligible 90 days after infusion if treatment, 30 days if prophylaxis. No deferral for other immunoglobulin therapy.*
□	MIS from COVID-19 infection	Requires attestation from physician *Eligible at least 90 days after recovery of cardiac function.*

□ I am requesting a medical exemption from COVID-19 vaccination for a reason not recognized by the CDC and not listed above.

- In space below, please describe in detail your medical condition and how it prevents you from receiving each of the 3 COVID-19 vaccines currently available (Pfizer, Moderna, and J&J). You may write on a separate page, if more convenient (provider will need your answer).
- Your provider will be required to confirm your condition and inability to receive any vaccine.

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COVID-19 MEDICAL ACCOMMODATION REQUEST
STUDENT/PARENT SIGNATURE PAGE

By signing this form, I verify that the above information is complete and accurate as of the date of submission, and I understand that any intentional misrepresentation contained in this request may result in disciplinary action, including termination of employment.

I further acknowledge and understand that if my request for an accommodation is approved and I receive a medical exemption from receiving any COVID-19 vaccine, I will be required, at least and as an accommodation, to comply with any COVID-19 testing, masking, physical distancing, and other preventive policies and/or protocols applicable to unvaccinated employees and others, as laid forth in BHS policies.

I also understand that my request for a medical accommodation may not be granted if it is fraudulent, not reasonable, or it creates an undue hardship for BHS, including increased safety risks for myself and/or others.

I understand that any medical determination and/or accommodation approved through this process is only in relation to the COVID-19 vaccine mandate. Any exemption granted may be reviewed and revoked in the future if new information warrants. I further understand that by signing this form, if granted an accommodation, my name and vaccination status will be shared to the extent necessary to ensure compliance with associated regulatory requirements for unvaccinated individuals.

As part of this request, I am authorizing my designated medical provider to release any and all medical materials requested as part of this review, including but not limited to clinical documentation, laboratory results, and imaging reports. I further authorize my provider to discuss my medical condition(s) related to this request with BHS staff tasked with reviewing my exemption request.

Moreover, I authorize BHS to review available electronic medical records, including those of Employee Health functions, as far as they pertain to this exemption request.

Any and all records accessed or received will be handled securely in compliance with HIPAA and other applicable state and federal regulations.

Student Name (Please Print) _____

Parent Signature: _____ Date: _____

COVID-19 Vaccine Medical Exemption Request
Part II: To be completed by employee's medical provider (pages 5-6)

Dear provider:

The BHS employe/volunteer named above is a patient of yours and is requesting a medical exemption from any COVID-19 vaccine for the reasons they state above. They are asking you to corroborate this medical condition as a contraindication for vaccination.

In the space below (or in a separate letter if more convenient), please explain how the patient's medical condition makes each of the three currently available COVID-19 vaccines (e.g., Pfizer, Moderna, and J&J) contraindicated. That is, you must explicitly state which COVID-19 vaccine(s) is contraindicated and why.

Once you have completed the materials including any relevant ancillary reports (labs, etc.), please return to the patient so they may submit everything to BHS for review.

If you do NOT agree that their medical condition is a contraindication, please discuss with the employee/volunteer and return these papers to them, unsigned.

Some additional guidance on contraindications:

- CDC webpage on clinical considerations on COVID-19 vaccination.
- Concern for side effects alone is not an indication for a medical exemption.
- The CDC and other organizations recognize pregnancy or future pregnancy as an indication for vaccination (NOT a contraindication).

If the CDC does not recognize your patient's medical condition as a contraindication to vaccination, you are encouraged to cite scientific reports from reputable sources to support your position.

You may want to make the completed packet part of the patient's medical record, for future reference.

The employee/volunteer must submit their exemption request to BHS by **the start date of the Junior Auxiliary Pilot Program.** We and they appreciate your timely attention to the request.

Explanation of medical contraindication to COVID-19 vaccination (please type or print clearly): **TO BE COMPLETED BY MEDICAL PROVIDER**

As a licensed medical provider, I attest that my patient has medical contraindication to all available COVID-19 vaccines, as described above. I therefore request that my patient be exempted from vaccination as required under the BHS policy.

I attest that the information I have provided is truthful and accurate to the best of my knowledge. I recognize this request will be reviewed by BHS, and that I may be contacted for additional details.

Print provider name (incl credentials): _____

Provider signature: _____ Date: _____

HR USE ONLY

Date of initial request:

Accommodation request:

□ Approved Date:
Additional details:

□ Denied Date:
Additional details: