**Genesis Health Care System**
**2021-2022 COVID-19 Vaccination Exemption Request (Medical)**

Genesis HealthCare System is accountable to the CMS Omnibus COVID-19 Health Care Staff Vaccination Interim Final Rule (the "ITR") that was issued by the federal government on November 5, 2021. The ITR requires all clinical and non-clinical employees, licensed practitioners, students, volunteers, contract staff, and successful applicants of Genesis to be fully vaccinated against COVID-19 unless they have requested and received a vaccination-related exemption and accommodation due to a sincerely held religious belief, practice, observance, or medical condition.

To request an accommodation for a medical condition, you must complete this form and have your health care provider complete Appendix A (document attached) and submit it to Human Resources by 5 PM on December 1, 2021. This deadline is required to assure all exemption requests can be considered in a timely fashion and in compliance with the ITR. Absent exceptional circumstances, no exemption requests will be considered after this date. Exemption requests will be considered on an individual basis only.

☐ **I am requesting an exemption from receiving the COVID-19 vaccination**

- **Medical Reason** (Must provide a completed Medical Certification from your healthcare provider – APPENDIX A attached). All contraindications to the vaccination and support for staff requests for medical exemptions must (1) be signed and dated by a licensed practitioner who is not the individual requesting the exemption and who is acting within their scope of practice; (2) identify which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member and the *recognized* clinical reasons for the contraindications; and (3) include a statement by the authenticating practitioner recommending that the staff member be exempted from the vaccination based on recognized clinical contraindications. (86 FR 61572). Providers should refer to the CDC guidance identifying clinical contraindications, *Interim Clinical Considerations for Use of COVID-19 Vaccines Currently Approved or Authorized in the United States*, available at www.cdc.gov.

*1. Please provide additional information about the reason for your decision not to be vaccinated against the COVID-19 virus below (including as applicable a description of your medical condition):*

**DO NOT PROVIDE INFORMATION ABOUT GENETIC TESTS, GENETIC SERVICES, OR ANY FAMILY MEDICAL HISTORY.**

_____

_____

You must provide a medical certification timely completed by your health care provider, confirming that you are under their care, and that they are recommending that you not be vaccinated as a result of your medical condition/need, in order for us to consider your request for an accommodation.

*2. If you have any suggestions or requests regarding what specific reasonable accommodations, if any, may be made to accommodate you, please state them here:*

_____

_____

*3. Please provide and/or attach any additional information that you believe might be useful as we consider your request. Depending on the information you provide, we may request additional follow up.*

_____

_____

Once we have received your request, we will contact you to assess the appropriate accommodation, if any, under the circumstances. Any request that we grant is conditional and subject to reconsideration based on business needs and Genesis policy, which we reserve the right to change at any time.

If you have any questions, please do not hesitate to contact Human Resources via their email inbox.

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By signing below, I acknowledge the following:

I have read and understand Genesis's COVID-19 Vaccination Policy. I understand that the accommodation requested above may not be granted but that Genesis will attempt to provide a reasonable accommodation that does not create an undue hardship on the company. I understand that Genesis may need to obtain supporting documentation regarding my medical disability to further evaluate my request for accommodation.

I authorize the release of requested information to Genesis's management as deemed necessary by Human Resources to facilitate this request for accommodation.

By my signature below, I attest that the information in this form, and any subsequent information provided by me as part of this process, is true and correct.

→ TODAY'S DATE _____PRINT NAME _____DOB _____

→ SIGNATURE _____EMPLOYEE NUMBER_____

DEPARTMENT _____MANAGER NAME_____

FOR HUMAN RESOURCES USE ONLY

Received in HR (date)_____BY_____

Review Date_____BY_____

**___Approved ___Denied ___Referred for Further Review**

**COMMENTS: _____**

**_____**

Communication to employee completed (date)_____ By_____

# APPENDIX A
# CERTIFICATION OF HEALTH CARE PROVIDER

# CERTIFICATION OF HEALTH CARE PROVIDER - COVID-19 VACCINE ACCOMMODATION

## SECTION I - EMPLOYER

(1) Employee name:_____
First Middle Last

(2) Employer name: _____ Date_____*(mm/dd/yyyy)*
*(List date certification requested)*

## SECTION II – HEALTH CARE PROVIDER

Your patient has requested an accommodation in the form of an exception to our COVID-19 vaccination policy. Please provide your contact information, complete the information below, and sign the form. Limit your response to the medical condition(s) for which the employee is seeking an exception to our COVID-19 vaccination policy. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b).

Health Care Provider's name: *(Print)* _____

Health Care Provider's business address:_____

Type of practice / Medical specialty: _____

Telephone: (_____) Fax: (_____) E-mail:_____

- The employee listed above is currently my patient and under my professional medical care.
- Please indicate below if your patient has a verifiable medical contraindication to receiving the COVID-19 vaccine. Please note that the currently available U.S. COVID-19 vaccines do not contain Thimerosal, eggs, antibiotics, or latex. Please check one of the following:

☐ Documented personal history of a severe allergic reaction (e.g., anaphylaxis) to a previous dose or component of a COVID-19 vaccine. Please indicate the specific vaccine and date of reaction:

COVID-19 Vaccine name: _____ Date: _____ Describe reaction: _____
_____

☐ Documented personal history of an immediate allergic reaction of any severity (such as urticaria, angioedema, respiratory distress within 4 hours following injection) to a previous dose or component of a COVID-19 vaccine. Please indicate the specific vaccine/vaccine component and date of reaction:
☐ COVID-19 Vaccine Name: _____ Date: _____ Describe reaction: _____
_____
☐ Polysorbate, Describe:_____
☐ Polyethylene Glycol (PEG), Describe: _____
☐ Other Vaccine Component: Describe: _____
☐ Other - Describe in specific detail the medical contraindication that would make receiving the COVID-19 vaccine unsafe, if not due to previous severe adverse reaction to a COVID-19 vaccine or one of its components. Please provide any citations to scientific evidence to be considered, and provide detailed medical information regarding your patient related to the contraindication.
This must be filled out by the treating physician: _____
_____
_____

☐ Due to his/her disability/medical condition, I am recommending that my patient not receive a COVID-19 vaccination.
☐ Due to his/her disability/medical condition, I am recommending that my patient delay receiving a COVID-19 vaccination until _____.

**Signature of Health Care Provider** _____ **Date**_____ *(mm/dd/yyyy)*