Medical Exemption Request Form

This form is to be completed by anyone requesting a medical exemption to the COVID-19 vaccine required by H&G Nursing Homes, Inc. due to a medical contraindication.

PART I: To be completed by the person requesting a medical exemption

Name: _____ Date of Request (MM/DD/YYYY): ____/____/_____

Date of Birth: _____ Phone #: _____ Email Address: _____

Work Location: _____ Department: _____ Job Title: _____

PART II: To be completed by primary care physician verifying the medical exemption

Request for Medical Exemption from COVID-19 Vaccination (To be completed by primary care physician verifying the medical exemption)

H&G Nursing Homes, Inc dba Adams County Manor and Morris Nursing Home requires SARS-CoV2 (COVID-19) vaccination(s) for all its employees, contracted personnel, students, trainees, volunteers and all who provide care or services to the facilities. Your patient is requesting to be exempt from this vaccination. Medical exemption from COVID-19 vaccination is allowed ONLY for recognized contraindications. The following is language from the CMS regulation:

"Documentation confirming recognized clinical contraindications to COVID-19 vaccinations for staff seeking a medical exemption must be signed and dated by a licensed practitioner, who is not the individual requesting the exemption and is acting within their respective scope of practice based on applicable state and local laws. This documentation must contain all information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications along with the duration of the need for an exemption and/or accommodation. Additionally, a statement by the authenticating practitioner recommending that the staff member be exempted from the Company's COVID-19 vaccination requirements is necessary."

Please complete the information below to request medical exemption for your patient. Should you have any questions, please call the Human Resources Department at (513) 964-4460.

My patient should not be vaccinated against COVID-19 for the following recognized contraindication to COVID-19 vaccination (please mark which one):

- ○ History of previous severe allergic reaction (e.g., anaphylaxis) to the COVID-19 vaccine or component of the vaccine defined as developing hives, swelling of the lips, throat or tongue, difficulty breathing, etc…Does not include sore arm, local reaction or subsequent upper respiratory tract infection.

Specify to which Vaccine: ○ Pfizer_BioNTech ○ Moderna ○ Johnson & Johnson/Janssen ○ Other

- ○ Documented allergy to polyethylene glycol (PEG)
- ○ Documented allergy to polysorbate
- ○ Other allergic reaction. Please describe: _____
- ○ Diagnosis of Multi-system Inflammatory Syndrome-Adults (MIS-A) (Accompanying medical documentation required)
- ○ Other: _____

"Other" requests will be reviewed on a case by case basis by the Exemption Request Review Committee. Clarification from the requesting employee and/or their physician may be requested in writing or by phone.

Please indicate the duration of the medical exemption and if/when vaccine can be safely administered.

- ○ Medical exemption is permanent
- ○ Medical exemption is temporary (one year or less) and resolution is anticipated by _____ (MM/DD/YYYY)
- ○ Medical exemption is due to pregnancy and estimated Delivery Date is _____ (MM/DD/YYYY)

Physician Name (Print): _____ Office Phone #: _____

Physician Email Address: _____

Physician Office Address: _____

Physician Signature: _____ Date: _____

Please submit completed form to exemption-request-committee@hg-nh.com or fax to 513-734-6319.

Request for Temporary Exemption from COVID-19 Vaccination for Pregnancy or Breast Feeding (To be completed by employee requesting temporary exemption)

I understand and acknowledge that COVID-19 vaccination is recommended in pregnancy by the Centers for Disease Control (CDC) and Prevention and the American College of Obstetricians and Gynecologists to protect pregnant women (who are at increased risk of severe disease) and to protect the baby after it is born. Nevertheless, I am requesting a temporary exemption from the mandatory COVID-19 vaccination as an accommodation while pregnant or breast feeding. I further understand that if a temporary exemption is approved, I will be required to meet accommodation criteria listed in the Company's policy. *(Please indicate below)*

○ Pregnant Expected Delivery Date: _____ (MM/DD/YYYY)

Physician/OBGYN/Midwife Name: _____

Address of Practice: _____

Practice Phone #: _____ Practice Email: _____

○ Breast Feeding Child's Date of Birth: _____ Estimated End Date of Breast Feeding: _____

Part III: To be completed by the Exemption Request Review Committee

○ Exemption APPROVED Was this Request Form accompanied by a separate physician statement or any other supporting medical documentation? ○ Yes ○ No
If yes, describe documentation: _____
_____
_____

○ Exemption DENIED If denied, describe reasoning (Use additional space on next page if needed): _____
_____
_____

○ Decision Letter has been sent to employee and contains required accommodation criteria

_____ _____ _____ _____
Review Committee Member Signature Date Review Committee Member Signature Date

adams county MANOR | H&G NURSING HOMES | MORRIS nursing home

Employee Name: _____

Additional Description/Comment/Accommodation information

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Print or copy additional pages if needed….