Southwestern Health Resources
Texas Health Resources | UTSouthwestern Medical Center

Request for Medical Exception from Vaccinations

Employee/Physician/Volunteer Name: (Print) _____ **THR Entity:** _____

Employee ID# or Last 4 of SS# _____ Department (s): _____ Position: _____

Personal Email: _____ Contact Phone Number: _____

Dear Treating Physician:

As a patient safety initiative, Southwestern Health Resources requires COVID-19. These vaccinations are recommended by the CDC in the Immunization of Health Care Workers, Recommendations of the Advisory Committee on Immunization Practices (ACIP) and the Hospital Infection Control/Practices Advisory Committee (HICPAC). They have been shown in study settings to be effective in preventing the spread of disease to patients. Your patient is requesting to be exempt from one or more of these vaccinations. Medical exemption from vaccinations is allowed for recognized contraindications only. (https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html).

Please complete the form below to request a medical exemption for your patient. This completed form must be returned to your patient for submission.

COVID 19	**My patient has the following checked contraindication(s) to COVID 19 vaccination**: Contraindications/Precautions:

- ☐ **INDEFINITE EXEMPTION** – Documented anaphylactic reaction to a prior dose of the vaccine or any of its components (e.g., Polyethylene glycol (PEG)
- ☐ **DEFERRAL** - Moderate to severe acute illness or fever, delay vaccination until: (Date Required) _____
- ☐ **DEFERRAL** – Active, confirmed pregnancy. Vaccination required upon completion of term or change in active pregnancy status:(Date Required) _____
- ☐ **DEFERRAL** – Recent diagnosis of COVID treated with monoclonal antibody therapy or convalescent plasma-vaccination cycle should start 90 days after treatment date: (Date Required) _____
- ☐ **DEFERRAL -** Delay vaccination until: _____ due to other medical condition: (Specify)_____

Request for medical exemption from vaccination will be reviewed by the Accommodation Review Committee.
Further clarification and/or additional supporting documentation may be requested.

I certify my patient has the above contraindication(s), and request a medical exemption from the vaccination(s) selected above:

Print Physician Name: _____ Phone #: _____

Physician Signature: _____ Date: _____

(Signature stamp is not acceptable)

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I _____ understand that my medical information is confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. The above information may be release to the Comprehensive Immunization Policy Vaccination Exemption Committee to validate medical vaccination exemption. ***Exemption requests other than "INDEFINITE" must be resubmitted annually. Electronic Readyset surveys MUST be completed annually.***

Employee/Physician/Volunteer Signature: _____

(Signature required prior to submitting for review)

Date: _____