COVID-19 VACCINATION RELIGIOUS EXEMPTION FORM

Employee Name: Date of Request:

Email: Telephone:

Position Title: Division:

Personnel #: Location:

Please describe how your sincerely held religious belief, observance or practice conflicts with the requirement to receive a vaccination for COVID-19.

By signing below, you affirm that the statements above are true and correct.

Signature Date

Accommodation Decision (this area will be completed by HR Compliance of DHS)

Date: ___________

Accommodation: ___ approved as identified below

___ not approved

Signature

- ☐ Produce negative result from a diagnostic test performed by a healthcare provider each week
- ☐ Produce negative result from a take home diagnostic test performed each week
- ☐ Wear a NIOSH-approved N95 mask, regardless of whether direct care is being provided to a patient

COVID-19 VACCINATION MEDICAL EXEMPTION FORM

All information regarding an individual's medical condition is protected and will be kept confidential. Further, all documents related to this request are kept confidential and will be maintained and used in accordance with the applicable state and federal law. **Please return this form to the requestor.**

Employee Name:	Date of Request:
Email:	Telephone:
Position Title:	Division:
Personnel #:	Location:

To Be Completed by Licensed Medical Practitioner
(Licensed Medical Practitioner is not employee requesting exemption and must be acting within their respective scope of practice.)

Do you believe that the above-identified employee has a contraindication to any of the currently available vaccines for COVID-19 and should be exempt from COVID-19 vaccination requirements?

☐ Yes
☐ No

If yes, please identify each of the vaccines for which you believe the above-identified employee has a contraindication.

☐ Pfizer/BioNTech
☐ Moderna
☐ Janssen/Johnson & Johnson

Please describe the clinical reasons for the contraindication.

____
____
____

Do you believe the contraindication is of a temporary nature?

☐ Yes
☐ No

If yes, for how long do you expect the contraindication will last? ______________________

Medical Practitioner's Name

Medical Practitioner's Signature

Field of Practice / License Number

Date

Address

Phone Number

Accommodation Decision (this area to be completed by HR Compliance of DHS)

Date: ___________

Accommodation: ___ approved as identified below ______________________________
___ not approved Signature

- ☐ Produce negative result from a diagnostic test performed by a healthcare provider each week
- ☐ Produce negative result from a take home diagnostic test performed each week
- ☐ Wear a NIOSH-approved N95 mask at all times, regardless of whether direct care is being provided to a patient
- ☐ Obtain first shot in two-series vaccine or single shot of a single dose vaccine by ________.
- ☐ Obtain final shot in two-series vaccine by ________.