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Medical Certification for Vaccine Exemption – Members

A Member may be exempted from one or more of the specific immunization requirements by written statement completed by a provider indicating the nature and probable duration of the medical condition or circumstances that contraindicates those immunizations, identifying the specific vaccines that could be detrimental to the individual's health.

Section I: Should be completed by the member

Name: _____ Date of Birth: _____
First/Middle/Last

Primary Home Address: _____

Email Address: _____ Primary Phone: _____

Signature: _____ Date: _____

Section II: Should be completed by medical provider

Medical contraindications and precautions for immunizations are based on the most recent General Recommendations of the Advisory Committee on Immunization Practices (ACIP), available at https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html. Please check the website to ensure that you are reviewing the most recent ACIP information. Please note that the presence of a sore arm, local reaction, and moderate to severe acute illness with or without fever are possible after administration of all vaccines. However, as acute illnesses are short-lived, medical exemptions should not be submitted for this indication. Please review the ACIP Guide to confirm that any noted condition is not commonly misperceived as a contraindication or precaution in the above ACIP link.

Table 1. ACIP Contraindications and Precautions to Vaccination

Vaccine	Exemption Length	ACIP Contraindications and Precautions (CHECK ALL THAT APPLY)
□ COVID-19	□ Temporary through: _____ □ Permanent	**Contraindications** □ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component of the COVID-19 vaccine **Explain in full below** □ Immediate allergic reaction of any severity to a previous dose or known (diagnosed) allergy to a component of the vaccine **Explain in full below** □ Other: **Explain in full below**

Other: Please explain fully the nature and probable duration of the medical condition or circumstances that contraindicate those immunizations, identifying the specific vaccines that could be detrimental to the employee's health. Attach additional sheets as necessary.

_____
_____
_____
_____
_____
_____

Attestation

I am a physician (M.D. or D.O.) licensed to practice medicine in a jurisdiction of the United States or an advanced practice provider (nurse practitioner or physician's assistant) licensed in a jurisdiction of the United States.

By signing below, I affirm that I have reviewed the current ACIP Contraindications and Precautions and affirm that the stated contraindication(s)/precaution(s) pose a concern or could be detrimental to this individual's health.

Healthcare Provider Name (please print): _____

Signature: _____ Date: _____

State of Licensure: _____ NPI Number: _____