INOVA

Vaccination Exemption Application – Non-COVID-19

Team Member Name:_____ Date of Birth: _____

Email Address:_____ Phone Number: _____

Team Member Status: ☐ Provider ☐ Inova-employed Team Member ☐ New Hire
☐ Vendor ☐ Volunteer ☐ Contractor ☐ Student

For Employed Team Members:

Employee/Provider ID: _____ Manager's Name: _____ Department: _____

For Non-Inova-Employed Team Members: School/Company/Affiliation: _____

I am requesting exemption for the following vaccination(s):

☐ Hepatitis B ☐ Influenza* ☐ Measles, Mumps and Rubella (MMR)
☐ Meningococcal ☐ Tdap (pertussis) ☐ Varicella (chicken pox)
☐ Other: _____

*If I am approved for an exemption from the influenza vaccination, I will be required to wear a surgical mask when I am at any Inova facility.

Medical Exemptions Application

I request a medical exemption for the following reason(s) (choose all that apply):

☐ I have a documented allergy to the following component of the vaccine: _____
☐ My history of the following medical condition contraindicates vaccination: _____
☐ I have a documented anaphylactic allergic reaction to the vaccine
☐ I have a documented severe adverse effect to the vaccine (specify): _____
☐ I am currently pregnant

I have attached a letter from my private provider or medical professional on his/her professional letterhead documenting my exact medical contraindication(s). ☐ Yes ☐ No

Religious Exemption Application

As a separate attachment, provide:

1. A description of the nature of your objection to the vaccination requirement.
2. How complying with the vaccination requirement would substantially burden your religious exercise.

OPTIONAL: I have attached a letter from my clergy/religious leader on his/her professional letterhead affirming consistency with prior vaccination history. ☐ Yes ☐ No

Team Member Attestation:

I understand that by not receiving these vaccinations, I may have an increased risk of contracting either the virus or its related complications. Accordingly, if I contract either virus, I understand that there could be life-threatening consequences to my own health and the health of those with whom I have contact, including any patients, team members, or my family and community.

I attest that the above information is complete and accurate to the best of my knowledge. I understand that any deliberate misrepresentation contained in this application could result in disciplinary action, including suspension or termination from duties at Inova. I also understand that my application for an exemption may not be granted if it creates undue hardship for Inova. I am aware that as Immunization policy requirements are updated, medical exemptions and associated criteria may be reassessed and updated accordingly.

Team Member (signature):_____ Date:_____ Time: _____

Submit completed Vaccination Exemption Application and or scan and email all documentation to:
exemptionrequests@inova.org and gmecredentialing@inova.org

Vaccination Exemption Application – COVID-19 Medical

Team Member Name: _____ Date of Birth: _____

Email Address: _____ Phone Number: _____

Team Member Status: ☐ Provider ☐ Inova-employed Team Member ☐ New Hire
☐ Vendor ☐ Volunteer ☐ Contractor ☐ Student

For Employed Team Members:

Employee/Provider ID: _____ Manager's Name: _____ Department: _____

For Non-Inova-Employed Team Members: School/Company/Affiliation: _____

Instructions: Give this form to your provider to complete and sign. After your provider has completed and signed the provider portion of the form, read, sign, and date the attestation at the bottom.

To Be Completed by Your Provider

A mandatory COVID-19 vaccination policy is in effect for all Inova Team Members including contract workers, credentialed staff providers, 100% remote workers, and students. A medical exemption from COVID-19 vaccination is only allowed for certain recognized medical conditions for which vaccines are contraindicated (as a reasonable accommodation under the Americans with Disabilities Act (ADA)). Refer to Center for Disease Control guidelines:

https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html

The above person should not be immunized against COVID-19 for the following reason(s): (Check all that apply. In order to process the exemption application, all relevant questions must be answered.)

Allergic Reactions:

☐ Documented severe allergic reaction (e.g., anaphalyaxis) after a previous dose, or known allergy to a component of the COVID-19 vaccine.
Describe the reaction in detail: _____
_____

☐ Documented immediate allergic reaction of any severity after a previous dose, or known allergy to a component of the COVID-19 vaccine.
Describe the reaction in detail: _____
_____

- If known, which ingredient caused the allergic reaction: _____
  Refer to: https://www.cdc.gov/coronavirus/2019-ncov/vaccines/faq.html?s_cid=10492:ingredients%20in%20the%20covid%2019%20vaccine:sem.ga:p:RG:GM:gen:PTN:FY21

- List the brand(s) of the COVID-19 vaccine(s) that were associated with allergic reactions: _____
  _____

- Has your patient seen an allergist? ☐ Yes ☐ No
  If yes, name of allergist: _____

- In your medical opinion, can an alternate COVID-19 vaccine type be given? ☐ Yes ☐ No
  (ex. the J and J vaccine in someone with an allergic reaction to mRNA vaccine – OR – mRNA vaccine in someone with an allergic reaction to the J and J vaccine.)

Other Temporary or Permanent Contraindications:

- Is this a temporary contraindication: ☐ Yes ☐ No
  If yes, indicate reason: _____
  How long will the temporary contraindication last? (list dates) _____

To Be Completed by the Provider (continued)

- Is this a permanent exemption? ☐ Yes ☐ No
  If yes, why? _____

- Is the contraindication indicated by a qualifying disability**? ☐ Yes ☐ No

  If yes, explain: (a) the nature of the impairment; (b) the major life activity or activities which are substantially limited by the impairment; and (c) why the impairment contraindicates vaccination.

  _____

  _____

  _____

  **For these purposes, "qualifying disability" means "a mental or physical impairment that substantially limits one or more major life activities, including the operation of a major bodily function."

In my medical opinion, the physical or medical condition is such that I do not advise my patient to receive the COVID-19 vaccine. I certify that my patient has the above contraindication(s) and recommend a medical exemption from the COVID-19 vaccination.

Provider (signature): _____ Date: _____ Time: _____

Provider (print name): _____ Medical License #_____ State: _____

Provider Note: Signature stamp is not acceptable. Attach a separate statement on your letterhead that describes the physical or medical reason(s) justifying an exemption. The explanation must detail the specific nature and probable duration of the condition or circumstances that contraindicate immunization with the COVID-19 vaccine. Provide any relevant peer-reviewed scientific evidence to support this exemption.

To Be Completed by Team Member

Team Member Attestation:

I understand that by not being up to date with COVID-19 vaccination, I may have an increased risk of contracting either the virus or its related complications. Accordingly, if I contract the virus, I understand that there could be life-threatening consequences to my own health and the health of those with whom I have contact, including any patients, team members, or my family and community.

I attest that the above information is complete and accurate to the best of my knowledge. I understand that any deliberate misrepresentation contained in this application could result in disciplinary action, including suspension or termination from duties at Inova. I also understand that my application for an exemption may not be granted if it creates undue hardship for Inova. I am aware that as Immunization policy requirements are updated, medical exemptions and associated criteria may be reassessed and updated accordingly.

Team Member (signature):_____Date:_____Time: _____

Submit completed Vaccination Exemption Application and or scan and email all documentation to:
exemptionrequests@inova.org and gmecredentialing@inova.org

Vaccination Exemption Application – COVID-19 Religious

Team Member Name:_____ Date of Birth: _____

Email Address:_____ Phone Number: _____

Team Member Status: ☐ Provider ☐ Inova-employed Team Member ☐ New Hire
☐ Vendor ☐ Volunteer ☐ Contractor ☐ Student

For Employed Team Members:

Employee/Provider ID: _____ Manager's Name: _____ Department: _____

For Non-Inova-Employed Team Members: School/Company/Affiliation: _____

An Inova Team Member may request an exemption from Inova's vaccination requirements due to religious reasons. To be eligible for such an exemption, your application must be based on a sincerely held religious belief and will require you to provide supporting documentation that will be reviewed and either approved or declined by committee. Exemption applications may be declined even if you are otherwise eligible if accommodating your request would pose an undue hardship to Inova operations.

Instructions: You must answer <u>all</u> the following questions on a separate attachment and submit them with your form for consideration. Inova may ask for other information as needed to determine whether an exemption will be granted.

1. Describe the nature of your objection to the vaccination requirement.
2. How would complying with the vaccination requirement substantially burden your religious exercise?
3. How long have you held the religious belief underlying your objection?
4. Describe whether, as an adult, you have received any vaccines against any other diseases (such as influenza, Measles, Mumps and Rubella (MMR), and Tdap (pertussis)).
5. If you do not have religious objection to the use of all vaccines, explain why your objection is limited to the COVID-19 vaccine.
6. Describe if there are any other medicines or products that you do not use because of the religious belief underlying your objection.

Provide any additional information (including, if applicable, a letter from your clergy/religious leader on his/her professional letterhead affirming religious belief in vaccine exemption) that you think may be helpful in reviewing your application.

Team Member Attestation:

I understand that by not being up to date with COVID-19 vaccination, I may have an increased risk of contracting either the virus or its related complications. Accordingly, if I contract the virus, I understand that there could be life-threatening consequences to my own health and the health of those with whom I have contact, including any patients, team members, or my family and community.

I attest that the above information is complete and accurate to the best of my knowledge. I understand that any deliberate misrepresentation contained in this application could result in disciplinary action, including suspension or termination from duties at Inova. I also understand that my application for an exemption may not be granted if it creates undue hardship for Inova. I am aware that as Immunization policy requirements are updated, medical exemptions and associated criteria may be reassessed and updated accordingly.

Team Member (signature):_____ Date:_____ Time: _____

Submit completed Vaccination Exemption Application and or scan and email all documentation to:
exemptionrequests@inova.org and gmecredentialing@inova.org

INOVA

Vaccination Exemption Application – Medical Exemption from Booster for Those with a History of COVID Who Received a Primary mRNA Vaccine Series

Team Member Name:_____ Date of Birth: _____

Email Address:_____ Phone Number: _____

Team Member Status: ☐ Provider ☐ Inova-employed Team Member ☐ New Hire
☐ Vendor ☐ Volunteer ☐ Contractor ☐ Student

For Employed Team Members:

Employee/Provider ID: _____ Manager's Name: _____ Department: _____

For Non-Inova-Employed Team Members: School/Company/Affiliation: _____

The criteria for medical exemption from a booster for those who have a history of COVID who received a primary mRNA vaccine series are:

- Age less than 50 years old
- Received two doses of mRNA COVID-19 vaccine
- Had previous COVID-19
- Are otherwise healthy (without conditions that are associated with severe illness due to COVID: https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html).

Follow these steps for a complete application for medical exemption from a booster if you had a history of COVID and received a primary mRNA vaccine series.

☐ Confirm you are under the age of 50 years old. If you are not under 50 years old, you do not meet criteria for this type of medical exemption.

☐ Confirm you have received two doses of mRNA COVID-19 vaccine (Pfizer or Moderna). If you have not received two doses of mRNA COVID-19 vaccine, you do not meet criteria for this type of medical exemption.

☐ Submit date of infection:_____ Our team will verify team member health records.

☐ Discuss the risks and benefits of a booster with your licensed provider.

☐ Submit this form if after a discussion with your licensed provider that you wish to proceed with submitting a medical exemption application.

Team Member Attestation:

I understand that by not being up to date with COVID-19 vaccination, I may have an increased risk of contracting either the virus or its related complications. Accordingly, if I contract the virus, I understand that there could be life-threatening consequences to my own health and the health of those with whom I have contact, including any patients, team members, or my family and community.

I attest that the above information is complete and accurate to the best of my knowledge. I understand that any deliberate misrepresentation contained in this application could result in disciplinary action, including suspension or termination from duties at Inova. I also understand that my application for an exemption may not be granted if it creates undue hardship for Inova. I am aware that as Immunization policy requirements are updated, medical exemptions and associated criteria may be reassessed and updated accordingly.

Team Member (signature):_____ Date:_____ Time: _____

Submit completed Vaccination Exemption Application and or scan and email all documentation to:
exemptionrequests@inova.org and gmecredentialing@inova.org