Advocate Aurora Health requires COVID-19 vaccinations for all team members including physicians, medical staff members and other privileged practitioners, students, remote workers, volunteers and vendors are required to get the COVID-19 vaccine. If you have a medical reason that you believe prevents you from receiving the COVID vaccine, you must submit this completed form by **08/27/2021**. The exemption request will be reviewed by a team of Advocate Aurora health care professionals. If your request is approved, you will be medically exempted from receiving the COVID-19 vaccine this year and generally for the duration of your employment with Advocate Aurora, unless the medical reason is situational, in which case a deferral will be granted. If your request is denied, you will be required to receive the COVID vaccine as a condition of your continued employment. Alternatively, you may submit an appeal of the denial within five (5) business days of the denial notification.

**HOW DO I APPLY FOR A MEDICAL EXEMPTION?**

 Complete the COVID-19 Vaccination Medical Exemption Request Form

1. Complete Section 1, and take the form to your health care provider (MD/DO, NP or PA)
2. Your health care provider should complete Section 2, **AND** provide you with supporting documentation (see below)
3. Even if you are a provider, you are not able to complete a medical exemption form for yourself.

 Supporting documentation

1. Medical documentation of a severe and/or life-threatening allergy (e.g. anaphylaxis) to a previous dose or to a component of the COVID-19 vaccine
2. Medical documentation of an immediate allergic reaction (occurring within 4 hours of administration) of any severity to a previous dose, or known (diagnosed) allergy to a component of the vaccine (e.g. hives)
3. Medical records supporting your request **MUST** be provided along with your request for exemption. These could include office, hospital, or emergency department records. The records should be included with this form.

**Examples of bases for medical exemption requests that will likely be denied:**

1. Egg allergy – eggs are not used in the manufacturing of COVID-19 vaccines.
2. Vegan diet – animal products are not used in the manufacturing of COVID-19 vaccines.
3. Immunocompromised – COVID-19 vaccines are not made from live viruses. Vaccination in immunocompromised persons is strongly encouraged.
4. Mild or nonspecific, non-allergic symptoms following previous COVID-19 vaccination (e.g. fever, arm soreness, diarrhea).
5. Panic attack, anxiety, or vasovagal reaction to a previous dose of a COVID-19 vaccine.
6. Recent vaccine administration- vaccines can be received concurrently based on CDC recommendations.
7. Food and/or environmental allergies.
8. History of Guillain-Barre syndrome: this has been associated only with Johnson & Johnson vaccine – Pfizer and Moderna vaccines are available.

**Examples of bases for medical exemption requests that will likely be deferred, which allow for temporary delays in receiving vaccines:**

1. Myocarditis or pericarditis after a first dose of Pfizer or Moderna vaccine
2. Current COVID-19 infection – vaccination should be deferred until the person has recovered from acute illness and no longer requires isolation
3. Received monoclonal antibodies or convalescent serum as treatment for COVID-19 infection – vaccination should be deferred until 90 days after receiving
4. History of multisystem inflammatory syndrome MIS-C (children) or MIS-A (adults) – vaccination should be deferred until after recovery and 90 days from date of diagnosis

**WHERE DO I SEND MY EXEMPTION REQUEST?**

Email completed exemption forms and all required documentation to: [AAH-covidexempt@aah.org](mailto:AAH-covidexempt@aah.org).

**MY MEDICAL EXEMPTION WAS DENIED. HOW CAN I APPEAL?**

A team member who is denied a request for a medical exemption can appeal in writing within five (5) business days of written denial notification. The appeal can be e-mailed to [AAH-covidexempt@aah.org](mailto:AAH-covidexempt@aah.org).

**IF MY EXEMPTION REQUEST IS APPROVED, WHAT WILL I NEED TO DO?**

If you are granted an exemption to the COVID-19 vaccine based on a medical condition, you are required to comply with the following conditions to remain employed at Advocate Aurora Health:

1. Must comply with current Advocate Aurora guidance on PPE use (add link)
2. Must comply with current Advocate Aurora guidance on travel and testing requirements
3. Must complete the then-current SafeCheck or daily COVID-19 symptom screening process prior to entering an Advocate Aurora site.

**WHO DO I CONTACT FOR MORE INFORMATION?**

Email all questions regarding medical exemptions to: [AAH-covidexempt@aah.org](mailto:AAH-covidexempt@aah.org).

**SECTION 1: To be completed by team member:**

|  |
| --- |
| Name: |
| Employee ID: Site/Department: |
| Date of Birth: |
| Phone #: |
| Email address where we may communicate approval/denial: |
| Please check one:  Team member, including employed physicians  Aligned provider   Volunteer  Other (specify): |

 If the Medical Exemption team requires more information from my provider, I understand that my exemption may be returned to me and the additional information will be needed by 08/27/2021 to process my exemption.

Team Member/Exemption Requestor Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SECTION 2: To be completed by health care provider**

**Step 1: Select the reason(s) for medical exemption**

 Severe and/or life-threatening allergy (e.g. anaphylaxis) to a previous dose or to a component of a COVID-19 vaccine

 Immediate allergic reaction of any severity (occurring within 4 hours of administration) to a previous dose or to a component of a COVID-19 vaccine (e.g., urticaria)

 Other: please provide detailed information describing the nature of the medical exemption request

**Step 2: Provide Medical Record Supporting the medical exemption reason.**

**Step 3: Complete the following:**

|  |
| --- |
| Provider’s Name (print): |
| Provider’s license #: |
| Street Address: |
| Phone #: Fax #: |
| Email: |

By my signature below, I attest the information provided on this form is true and accurate.

Provider Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_