**FORM B**

**COVID-19 Vaccine Declination Form – Qualifying Medical Reason**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (“\_\_\_\_\_”), in compliance with California Department of Public Health State Public Officer Order, requires that its workers be fully vaccinated against COVID-19. To decline the required COVID-19 vaccination due to a qualifying medical reason, please complete Section 1, below, and have your licensed healthcare provider complete Section 2 before returning this form to [CONTACT]. *Please do not identify any diagnosis, disability, or other medical information in this form.*

**Section 1**

|  |  |
| --- | --- |
| Name (print): | Date: |
| Dept.:  | Position: |
| Manager: | Phone: |

**By signing below and submitting this form, I am declining the COVID-19 vaccination on the basis of a qualifying medical reason.**

I verify that the information I am submitting to substantiate my request for exemption from \_\_\_\_\_\_\_\_\_\_’s mandatory vaccination policy is true and accurate to the best of my knowledge. I understand that any false or misleading information provided in support of this exemption request can lead to disciplinary action, up to and including termination.

I further understand that if this exemption is granted, that I will comply with all mandatory non-pharmaceutical interventions (including but not limited to face coverings and regular asymptomatic testing) that apply or may in the future apply to non-fully vaccinated workers. I understand that these mandatory interventions are required of me by State Public Health Officer Order and other applicable public health and safety requirements.  I understand that should I fail to comply with any applicable restrictions, that I may be barred from the premises, or subject to discipline, up to and including immediate termination.

By signing below, I attest under penalty of perjury that the information provided within this form and any associated attachments is true and correct.

|  |  |
| --- | --- |
| Employee Signature: | Date: |

**Section 2**

**Medical Certification for COVID-19 Vaccination Declination**

Employee Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dear Provider:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (“\_\_\_\_\_”) requires that its workers be vaccinated against COVID-19 as mandated by the California Department of Public Health State Public Health Officer Order of August 5, 2021. The individual named above is seeking an exemption to this policy due to a qualifying medical reason.

Please complete this form in its entirety.

|  |
| --- |
| **I certify that the person named above:**  **Qualifies** **Does Not Qualify** **for a medical exemption from \_\_\_\_\_’s mandatory vaccination policy due to a qualifying medical reason.** |
| **This exemption should be:*** Temporary, expiring on: \_\_\_\_/\_\_\_\_/\_\_\_\_, or when \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Permanent/Unknown
 |

*IMPORTANT NOTE: The federal Genetic Information Nondiscrimination Act of 2008 (“GINA”) and the California Genetic Information Nondiscrimination Act of 2011 (CalGINA) prohibit employers and other covered entities from requesting, or requiring, genetic information of an individual or family member of the individual except as specifically allowed by law. To comply with these laws, we are asking that you not provide any genetic information when responding to this request for medical information. As defined by GINA and CalGINA, “Genetic Information” includes an individual’s family medical history, information about the individual’s or the individual’s family member’s genetic tests, information regarding the manifestation of a disease or disorder in a family member of the individual, the fact that an individual or an individual’s family member sought or received genetic services, and information from genetic services or participation in clinical research that includes genetic services by an individual or any family member of the individual. It also includes genetic information of a fetus carried by an individual or an individual’s family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. Genetic Information does not include information about an individual’s sex or age.*

I certify the above information to be true and accurate, and submit this information in support of the requested exemption from COVID-19 vaccination for the above-named individual.

|  |
| --- |
| Provider Name (print): |
| Provider Signature: | Date: |
| Practice Name & Address: | Provider Phone: |

**INTERNAL USE ONLY**

Date of initial request: ­\_\_\_/\_\_\_/\_\_\_\_ Date certification received: \_\_\_/\_\_\_/\_\_\_\_

Exemption request:

 Approved \_\_\_/\_\_\_/\_\_\_\_. This approval is valid until \_\_\_/\_\_\_/\_\_\_ or [indefinitely].

* Denied \_\_\_/\_\_\_/\_\_\_\_.