**FORM C**

**COVID-19 DECLINATION FORM**

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

# I understand that on August 5, 2021, the Director and State Public Health Officer (the “Director”) for the California Department of Public Health issued *Health Care Worker Vaccine Requirement* (the “Order”), which requires vaccination against COVID-19 for health care facility workers. Workers must receive either their first dose of a one-dose regiment or the second dose in a two-dose regiment no later than September 30, 2021.[[1]](#footnote-1)

# By signing this declination form, I acknowledge that I have read and understand its contents and am declining the COVID-19 vaccine due to qualifying medical reasons or a sincerely held religious belief. If requested, I can provide documentation supporting an exemption.

# Declination of Vaccination:

* I am declining vaccination due to qualifying medical reasons or a sincerely held religious belief.
* I understand that I may be at risk of contracting COVID-19 and/or spreading it to others.

**Reason for declining:** (Please check all that apply).

## I request an exception due to qualifying medical reasons.[[2]](#footnote-2)

I request an exemption due to a sincerely held religious belief.

**I understand that I may not be able to continue to be employed if I do not receive a COVID-19 vaccination within the timeframes established by the Order or otherwise receive an approved exemption due to qualifying medical reasons or a religious accommodation request.**

**I also understand that if this exemption is granted, I will comply with any and all mandatory non-pharmaceutical interventions that apply or may apply in the future to non-fully vaccinated workers performing my job function.  I understand that, to the extent that any of these mandatory interventions are required of me by the Director’s Order, I will comply with all of them as well as any 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.**

**I further understand that EMPLOYER NAME is not required to provide this exemption if doing so would pose a direct threat to myself or others in the workplace, if I cannot perform my essential job function without creating an undue burden on my employer or if doing so would violate the Director’s Order.**

**Employee Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

**Request for Exception from COVID-19 Vaccination due to Qualifying Medical Reasons**

**I am requesting a Medical Exception due to qualifying medical reasons and take responsibility to have this physician’s statement completed by a physician, nurse practitioner, or other licensed medical professional practicing under the license of a physician and submitted to EMPLOYER NAME for the request to be considered.**

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

**Employee Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Employee Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Employee Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­**

**Employee Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Department: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physician Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Dear Physician:

On August 5, 2021, the Director and State Public Health Officer for the California Department of Public Health issued *Health Care Worker Vaccine Requirement*, which requires vaccination against COVID-19 for health care facility workers. The above-named employee is requesting an exemption from this requirement due to qualifying medical reasons. A medical exception from vaccination is allowed for certain recognized qualifying medical reasons.

Below, please certify the qualifying medical reason(s) that prohibits your patient from vaccination against COVID-19. Please attach available supporting documentation and whether the exemption is permanent or temporary. The information provided on this form will be reviewed in consideration of the exemption request. **Please check the option that applies and provide further explanation for this medical exemption.**

**□ Option 1 - Physical Condition/Medical Circumstance**

The physical condition or medical circumstances relating to the patient are such that vaccination is not considered safe. Please state, with sufficient detail for independent medical review, the specific nature and probable duration of the medical condition or circumstances that contraindicate vaccination against COVID-19.

**□ Option 2 - Allergy**

History of a severe allergic reaction to any component of the COVID-19 vaccine or to a substance that is cross-reactive with a component or history of a severe allergic reaction after a previous dose of the COVID-19 vaccine. Please indicate which of the vaccines are contraindicated and name each applicable component.

Please indicate the date and type of the adverse reaction experienced after a previous dose of the COVID-19 vaccination and name of the vaccination.

**□ Option 3 - Other**

Please indicate the medical condition or disability that you opine would exempt this individual from vaccination.

Explanation of Medical Exemption: (Attach additional documentation if needed).

I certify that **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** has the above qualifying medical reason(s) and cannot receive the COVID-19 vaccination.

**Physician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

**Medical License Number:** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Request for Religious Exemption**

**Related to COVID-19 Vaccination**

**I am requesting a Religious Exception and take responsibility to have this form completed and submitted to EMPLOYER NAME for the request to be considered.**

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

**Employee Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Employee Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Employee Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Department: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

To consider your request for a religious exemption, please describe the reason for an exemption. Attach documentation or other authority to support the need for an accommodation based on your religious practice or belief.

**Religion Tenet(s) Documentation**

We may need to discuss the nature of your religious belief(s), practice(s) and exemption with your religion’s spiritual leader (if applicable) or religious scholars to address your request for an accommodation.

**Verification and Accuracy**

I verify that the above information is complete and accurate to the best of my knowledge, and I understand that any intentional misrepresentation contained in this request may result in disciplinary action.

**Employee Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

**FACILITY USE ONLY**

**Employee Name:**

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

Accommodation request:

* Approved \_\_/\_\_/\_\_\_\_

Describe specific accommodation details: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

Describe why accommodation is denied: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. Resources regarding the risks and benefits of vaccination against COVID-19 are available at <https://covid19.ca.gov/vaccines/>. [↑](#footnote-ref-1)
2. The below form, *Request for Exemption from COVID-19 Vaccination due to Qualifying Medical Reasons*, must be signed by a physician, nurse practitioner, or other licensed medical professional practicing under the license of a physician. [↑](#footnote-ref-2)