

COVID-19 MANDATORY VACCINATION DECLINATION HEALTHCARE PROVIDER SUPPORTING STATEMENT

In order for a person who works, provides services, or volunteers in Health Care Facilities subject to the August 5, 2021 or August 19, 2021 State Public Health Officer Order to qualify for a Medical/Disability Accommodation to the requirement to receive a COVID-19 vaccination, their healthcare provider (only a physician, nurse practitioner, or other licensed medical professional practicing under the license of a physician) must complete the following form to be provided by the person to their employer or other Business location where they work or volunteer.

NOTE – Do not state the nature of the underlying medical condition or disability.

Name of person seeking a medical/disability exemption: _____

Date of birth of person seeking exemption: _____

Name of physician, nurse practitioner, or other licensed medical professional practicing under the license of a physician: _____

Anticipated duration of medical condition/disability (or indicate if the duration is unknown or permanent):

By completing and signing this form, I certify that my client/patient listed above should not receive the COVID-19 vaccine due to (explain the specific contraindication to vaccination here, but do not identify the underlying medical condition or disability – attach a separate sheet or statement if necessary):

I certify the above information to be true and accurate, and I request exemption from the COVID-19 vaccination for the above-named individual.

Signed by: _____ Dated: _____

Printed Name: _____

License number: _____

Contact info (address and telephone number): _____

If practicing under the license of a physician, name and license number of physician:
