SUFFOLK COUNTY WATER AUTHORITY

Request for Medical Exemption from COVID-19 Vaccination Requirement

Name:_____

Department: _____

Phone: _____

SCWA policy requires all new and existing employees receive a COVID-19 vaccination. A medical exemption may be granted upon receipt of a completed form (below) not more than 6 months old, signed and certified by a licensed healthcare provider, not related to you, and whose specialty is appropriate to the associated condition listed as the basis for the exemption.

Medical exemptions expire when the medical condition(s) contraindicating COVID-19 immunization changes in a manner which permits immunization, as determined by SCWA in reviewing the request.

Individuals with an approved exemption will be required to comply with SCWA's Mandatory COVID-19 Testing Program and other preventive requirements.

Your request will be carefully reviewed and SCWA will have a conversation with you about it. After your request has been reviewed and processed, you will be notified, in writing, if an exemption has been granted or denied. If the approved exemption contains an expiration, you will be expected to complete the requirement at that time. Should the condition continue, or a new immunization contraindication occur, a new request with updated documentation is required. SCWA's decision to grant or deny your exemption request is final and not subject to appeal. Individuals whose requests have been denied are permitted to reapply if new documentation and information should become available.

Certification

I certify that the information contained in this request is true to the best of my knowledge and I have not provided false, misleading, or incomplete information to my provider in their review of my request. If my conditions change or the basis of my exemption expires, I agree to notify SCWA. If the exemption is granted, I agree to comply with SCWA's Mandatory COVID-19 Testing Program and other preventative measures.

Signature: _____

Name: _____

Date: _____

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Medical Provider Statement

Attention Health Care Provider:

SCWA policy requires that all new and existing employees receive a COVID-19 vaccination. _____ (insert patients name) is requesting a medical exemption from this vaccination requirement. A medical exemption may be allowed for certain recognized contraindications.

Please certify below the medical reason that your patient should not be immunized for COVID-19 by completing this form and attaching available supporting documentation. Information provided on this form will be reviewed by SCWA in consideration of the exemption request.

Date of Last Examination of Patient: _____

An exemption may be based on the following options.

Option 1 - Allergy

☐ A documented history of a severe allergic reaction to any component of a COVID-19 vaccine or to a substance that is cross-reactive with a component. Please indicate which of the following vaccines are contraindicated and name the components, by vaccine NOTE: since egg-free vaccine is available, history of egg allergy will not be accepted as a routine medical exemption.

Moderna - List the component(s):_____

Pfizer - List the component(s):_____

Johnson & Johnson (J&J)/Janssen - List the component(s): _____

☐ A documented history of a severe allergic reaction after a previous dose of the COVID-19 vaccine. Please indicate to which vaccine the patient had a reaction and the date of the vaccine and reaction.

Moderna - Date of Vaccine & Reaction:_____
_____

Pfizer - Date of Vaccine & Reaction:_____
_____

Johnson & Johnson (J&J)/Janssen - Date of Vaccine & Reaction: _____
_____

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Option 2 Physical Condition/Medical Circumstance

☐ The physical condition of the patient or medical circumstances relating to the individual are such that immunization 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 immunization with the COVID-19 vaccine.

Explanation:

Please attach separate sheet setting forth the explanation.

Option 3 - Other

☐ Other. Please provide this information in a separate narrative that describes, in detail, the medical condition or disability in detail that you opine would exempt this individual from vaccination.

Explanation:

Please attach separate sheet setting forth the explanation.

Certification

I certify that _____ (patient name) has the above contraindication and support the request for a medical exemption from SCWA's COVID-19 vaccine requirement at SCWA and it is made on the basis of my actual examination of the patient.

Provider Information:

Signature: _____

Medical Provider Name: _____

Medical Provider Specialty:_____

Medical Provider License Number_____

Date: _____