



UConn Health Mandatory COVID-19 Vaccination Policy Medical Exemption, Medical Deferral, or Personal Deferral Request

Instructions

In our continued effort to protect the safety of our patients, colleagues, and community, UConn Health is requiring all of UConn Health Workforce Members to be fully vaccinated against COVID-19. Dose #1 must be received by September 10, 2021 and dose #2 (if applicable) by October 15, 2021. UConn Health permits individuals to apply for a medical exemption, medical deferral, or personal deferral by using this form. **All requests are pending until you receive notice of an approval or denial. If no decision has been made by September 10th, requestors must comply with the protective guidelines (including weekly testing and enhanced PPE) outlined in this form until a decision is made. Individuals who are denied an exemption after September 10th shall have ten (10) days from the date of the notice of the denial to receive the vaccine (either a single dose vaccine or first dose of the 2 dose vaccine).**

Medical Exemptions or Deferrals: If you believe that you have a medical reason that prevents you from receiving the COVID-19 vaccine, you must upload this completed form. You should complete Section I, and take the form to your healthcare provider (MD, DO, NP, or PA). Your healthcare provider should complete Section II, and provide you with supporting documentation at the time of your visit.

Section I of this form **must** be completed, signed, and uploaded no later than **August 30, 2021** in order to be granted an exemption. Section II **must** be completed, scanned, and uploaded not later than thirty (30) days from the date of submission Section I. Incomplete forms will not be considered.

All requests will be reviewed by the Medical Exemption/Deferral Review Committee. The Medical Exemption/Deferral Review Committee reserves the right to confirm with your healthcare provider the information provided.

Personal Deferrals: If you are currently out on block leave, pregnant, or breastfeeding, please complete, sign, and upload Section I no later than **August 30, 2021**. All requests will be reviewed and confirmed by Human Resources. Human Resources may contact you for additional information regarding your request.



**UConn Health Mandatory COVID-19 Vaccination Policy
Medical Exemption, Medical Deferral, or Personal Deferral Request**

SECTION I: INDIVIDUAL COMPLETES THIS SECTION

Name: (Last)	(First)
Date of Birth:	
Position/Job Title:	
Department:	Manager/Supervisor:
Badge ID Number:	Employee ID (if applicable):
Email:	Phone Number:

Please check if you are requesting an exemption or a deferral and provide the condition for which you are seeking exemption or deferral:

I am requesting a medical exemption from COVID-19 vaccination.

Condition:

I am requesting a medical deferral from COVID-19 vaccination.

Condition:

I am requesting a personal deferral from COVID-19 vaccination.

Select reason for personal deferral:

I am currently on block leave and will not return until after September 10, 2021.

Details:

I am pregnant.

Anticipated Delivery Date:

I am actively breastfeeding.

Until (if known):

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By signing this form, you hereby authorize the Medical Exemption/Deferral Review Committee and Human Resources to contact you or your medical provider regarding conditions that prevent you from receiving the COVID-19 vaccination. You further acknowledge that if your request is approved, you will be exempted or deferred from receiving the COVID-19 vaccine and you will be required to comply with all of the following:

- **Receive a weekly COVID-19 NAAT or PCR testing. Full instructions to follow on how Workforce Members can schedule and fulfill their weekly testing requirement.**
- **Must follow the present travel guidelines for out-of-state travel with HR documentation and obtain a COVID-19 NAAT or PCR (not rapid antigen) test before returning to work following any out-of-state travel that lasts 24 hours or more. Additional testing following travel may be required under the instruction of the COVID-19 Call Center clinicians.**
- **Be required to wear a mask at ALL times while working and required to wear protective eyewear when providing clinical care to all patients and an N95 or equivalent respirator when performing any aerosol-generating procedure on any patient.**

Updates to these requirements may be made based on evolving state and federal public health guidance.

You understand that by signing this form, if granted an exemption or deferral, your name and vaccination status will be shared to the extent necessary to ensure compliance with health and safety requirements for unvaccinated individuals. You agree to comply with these restrictions and accept the responsibility for compliance with all health and safety requirements.

Also by signing this form, you understand and assume the risks of non-vaccination. You understand that COVID-19 vaccination is recommended to protect yourself, your patients, and your co-workers from COVID-19 and its complications, including serious illness and death. You hereby agree to comply with all safety measures listed in the preceding paragraph as well as any other necessary and reasonable safety measures.

If your request for an exemption is not approved, and you do not otherwise receive a deferral of this requirement, you will be required to receive the COVID-19 vaccine as a condition of your continued employment. **Individuals who have been denied an exemption shall have ten (10) days from the date of the notice of the denial to receive the vaccine (either a single dose vaccine or first dose of the 2 dose vaccine).**

I acknowledge that I have read the CDC Covid-19 Vaccine Information (<https://www.cdc.gov/coronavirus/2019-ncov/vaccines/index.html>).

Signature: _____

Date: _____

Printed/Typed name: _____

SECTION II: MEDICAL PROVIDER COMPLETES THIS SECTION

Step 1: Select the reason for exemption

- A documented history of severe or immediate-type allergic reaction to any ingredient of all currently available COVID-19 vaccine brands. (Vaccine ingredients for each of the vaccine brands is available at: <https://www.cdc.gov/vaccines/covid-19/eua/index.html>). List vaccine ingredient(s) the patient is allergic to:

Details: _____

- A documented history of severe allergy or immediate-type hypersensitivity reaction to a previous COVID-19 vaccination, and also a separate contraindication to all currently available COVID-19 vaccine brands.

Details: _____

- For the J&J/Janssen vaccine: A history of a specific heparin allergy known as heparin-induced thrombocytopenia (HIT) may be a contraindication or reason to defer the vaccination.

Details: _____

- Other - medical condition that requires employee to not receive the vaccination or delay until a future date.

Details: _____

The following conditions are not considered medical contraindications to COVID-19 vaccination but for which a deferral of the vaccination to a later date is being requested:

- Medication-induced immunocompromised states, especially when the medication is temporary and the vaccine is predicted to have better efficacy with future administration. Ideally though the vaccination should be given at least 2 weeks before the initiation of such immunosuppressive medications.

Details: _____

- Prior positive COVID-19 test: *If they test positive for COVID-19 before their first vaccine or after the first vaccine but prior to the second vaccine, they should wait 10 days from the positive test (or 90 days if they received treatment with Monoclonal Antibody Infusion) and be fully recovered s before receiving the first or second dose as appropriate.*

Details: _____

- Upcoming surgery: If an individual is scheduled for an upcoming surgery, they should consult with the surgeon to determine if their vaccination should be scheduled to a later date.

Details (including when the individual should be able to get vaccinated): _____

Note: The following conditions are **not** considered medical contraindications to COVID-19 vaccination:

- A history of allergy or anaphylaxis to foods, antibiotics, other oral medications, pets, venom, other

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- environmental allergies, or non-COVID vaccines
- A history of latex allergy
- Individuals who do not eat eggs or gelatin
- Family history of adverse vaccine reactions or autoimmune conditions
- Fear of needles or general avoidance of vaccines

Add any supporting data (please include any pertinent labs or studies, specialist notes, etc.)

Exemption is temporary and vaccination can be initiated at a date: _____

Anticipated duration of temporary exemption: _____

Provider's Signature: _____

Date: _____

Step 2: Complete the following:

Print Provider's Name: (Last)	(First)
Provider's Street Address:	City/State/Zip Code:
Phone Number:	Fax Number:
Specialty:	

Attention Provider and Colleague

ATTACH MEDICAL RECORDS

Please attach medical records or progress/visit notes that specifically indicate the contraindication/s for the patient receiving the COVID-19 vaccine. **Please note that the entire patient chart is not required** - only the **progress/visit note** of the healthcare provider **demonstrating contraindications to the COVID-19 Vaccine is required.**