CMH Caregiver COVID-19 Vaccine Medical Exception Request Form

Directions: CMH Caregiver requesting medical exception must personally complete Part A and C, and their health care provider must complete and sign Part B.

Part A: CMH Caregiver Name and Identifying Information

Name:_____

Mailing Address:_____

City:_____ State:_____ Zip Code:_____

Preferred Phone:_____Preferred Email:_____

Preferred Method of Contact: _____ Employee ID #:_____

Job Title:_____Manager/Supervisor:_____

Department:_____

Part B: Medical Exception Request (to be completed by medical provider)

Length of time you have had a provider-patient relationship with the patient:

_____

☐ The patient may receive a COVID-19 vaccination.

☐ The patient may not receive a certain type of COVID-19 vaccination. The patient may receive a vaccination manufactured by _____.

Medical Provider Certification: I certify that my patient (named above) should not be vaccinated against COVID-19 because:

☐ They have a history of severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a component of the COVID-19 vaccine

☐ They have a history of immediate allergic reaction of any severity to a previous dose or known (diagnosed) allergy to a component of the vaccine (see https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html#Appendix-C) which is defined as any hypersensitivity-related signs or symptoms consistent with urticaria, angioedema, respiratory distress (e.g., wheezing, stridor), or anaphylaxis that occur within four hours following administration.

☐ Other documented medical condition which prevents them from receiving the COVID-19 Vaccine (please specify):

COLUMBIA MEMORIAL HOSPITAL

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Is the medical condition permanent?: ☐ **Yes** ☐ **No**

Is the medical condition temporary?: ☐ **Yes** ☐ **No**
If yes, what is the expected duration:

_____

Please describe how this medical condition impacts their ability to receive the COVID-19 vaccination.

_____

_____

_____

_____

Length of time you have treated the patient for this medical condition.

_____

I have reviewed the above information and the risks and benefits of COVID-19 vaccination with the above-listed individual, and I certify the above information to be true and accurate.

Name and credentials of healthcare provider (print): _____

Signature: _____

License Number: _____

Phone: _____

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Part C: CMH Caregiver Attestation:

CMH's position is that COVID-19 is a highly contagious respiratory virus that affects people of all ages. This virus can cause long-term medical problems and death regardless of age. This virus spreads through respiratory secretions related to speaking, singing, yelling, coughing, and sneezing. Infected individuals can spread the virus to others. Up to 50% or more of people can be infected without realizing it. The COVID-19 vaccines are very safe and highly effective at preventing death and hospitalization. When large numbers within a population are immunized, viral spread will be significantly limited and the development of viral variants can be slowed. Each individual of a community can contribute to this protective approach.

By signing this form, I acknowledge and affirm that:

- I have read and understand the information on this form.
- I am requesting an exception from receiving the COVID-19 vaccination for the reason indicated in Section B above.
- CMH recommends individuals receive COVID-19 vaccination.
- If I want to, I have been able to ask questions and have my questions answered.

By signing this form, I declare and acknowledge that I have read and understand the information on this form. I am declining the COVID-19 vaccine.

Signature of CMH Caregiver: _____ **Date**: _____

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

I authorize [*provider's name(s)*] _____ to use and disclose a copy of the specific health information described below regarding [*employee/applicant's name*] _____ _____, date of birth _____, consisting of:

_____

to: Columbia Memorial Hospital
Human Resources
2111 Exchange Street
Astoria, OR 97103
hrdept@columbiamemorial.org
fax: 503.338.4016

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This information is being provided to CMH's Exception Review Process for the purpose of evaluating and facilitating the request for accommodation.

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

_____ HIV/AIDS-related records*

_____ Mental health information*

_____ Substance use disorder, diagnosis, treatment or referral**

** Must be initialed to be included in other documents.*
*** Federal regulation, 42 CFR Part 2, requires a description of how much and what kind of information is to be disclosed.*

This authorization does not cover, and the information to be disclosed should not contain, genetic information. "**Genetic information**" includes: Information about an individual's genetic tests; Information about genetic tests of an individual's family members; Information about the manifestation of a disease or disorder in an individual's family members (family medical history); An individual's request for, or receipt of, genetic services, or the participation in clinical research that includes genetic services by the individual or a family member of the individual; and Genetic information of a fetus carried by an individual or by a pregnant woman who is a family member of the individual and the genetic information of any embryo legally held by the individual or family member using an assisted reproductive technology.

This authorization is limited to the following treatment or time period:

_____

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, and substance use disorder, diagnosis, treatment or referral information.

You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services is if the healthcare services are solely for the purposes of providing health information to someone else and the authorization is necessary to make that disclosure. Your refusal to sign this authorization does not adversely affect your enrollment in a health plan or eligibility for health benefits, unless the authorized information is necessary to determine if you are eligible to enroll in the health plan.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purpose described in this written authorization. The only exception is when a covered entity has taken action in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance coverage.

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To revoke this authorization, please send a written statement to:

Columbia Memorial Hospital
Human Resources
2111 Exchange Street
Astoria, OR 97103
hrdept@columbiamemorial.org
fax: 503.338.4016

SIGNATURE

I have read this authorization and I understand it.

Printed Name: _____

Expiration Date of Medical Release:* _____

Signature: _____

Today's Date: _____

***** Unless otherwise indicated, this authorization expires one year from the date this release is signed.

Email completed form to hrdept@columbiamemorial.org