

COVID-19 Vaccination Requirement
Medical Exemption Request Form

Employee Name: _____ Employee ID #: _____

Department: _____

Job Title: _____

Please write your initials in the space next to “Acknowledged” to confirm that you have read and understand that statement.

Emory School of Medicine requires COVID-19 vaccination of our employees to prevent COVID-19 and its complications, including death. Acknowledged _____

Due to my job, if I am unvaccinated and do not follow masking and social distancing guidelines, I may give COVID-19 to my patients, my teammates, my family and/or friends, even if I have no symptoms. Acknowledged _____

I have received education about the effectiveness of COVID-19 vaccinations, as well as possible adverse events. Acknowledged _____

I cannot get COVID-19 from the COVID-19 Vaccine. Acknowledged _____

I acknowledge my responsibility to only request a medical exemption if truly necessary. Acknowledged _____

Even though I can receive the COVID-19 vaccine at no charge, I want a medical exemption from taking the COVID-19 vaccine. Acknowledged _____

Do you provide direct patient care? (Please select a response): Yes _____ No _____

Has Emory University or Emory Healthcare granted you an exemption from any other mandatory vaccine requirement in the past? Yes _____ No _____

List Exemption Reason:

_____ I have severe, life-threatening allergies to the COVID-19 vaccine or an ingredient in the vaccine.

_____ I have had a severe, life-threatening prior reaction to the COVID-19 vaccine.

_____ I have a current medical condition that prohibits me from obtaining the COVID-19 vaccine.

Please describe that condition below:

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MEDICINE

Employee Name: _____ Employee ID #: _____

Business Unit: _____ Department: _____

A signature from a licensed healthcare provider is required to validate a medical contraindication that does not allow you to get the COVID-19 vaccine.

Physician Signature/Date:

Physician Name (Please Print):

Physician Contact Phone Number: _____

To be considered for a medical exemption, you must provide documentation from a licensed healthcare provider supporting your request. This should include medical records with the reaction or other medical reason for the exemption. Please submit your documentation with this completed form. Requests will not be considered without documentation.

I understand that my request may not be granted if it is unreasonable, creates undue risk to patient safety or if it creates an undue hardship on my employer. Acknowledged _____

Date: _____ Employee or Applicant ID # _____

Print Name: _____ Signature _____

Please upload this form into the School of Medicine exemption application once completed.