EMORY
UNIVERSITY
SCHOOL OF
MEDICINE

COVID-19 Vaccination Requirement
Request for Deferral Due to Pregnancy

Employee Name: ____________________________ Employee ID #: ___________________________

Department:____

Job Title: ____

Please write your initials in the space next to "Acknowledged" to confirm 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 understand that infection with COVID-19 during pregnancy can pose significant risks to me and my baby. The COVID-19 vaccine reduces those risks. Acknowledged ________

I understand scientific evidence shows it is safe to get the COVID-19 vaccine during pregnancy. It reduces the risks associated if I am infected with COVID-19 during pregnancy. Acknowledged ______

I acknowledge my responsibility to only request a temporary exemption if truly necessary. Acknowledged ________

Even though I can receive the COVID-19 vaccine at no charge to myself, I want a deferral. 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_____________

Please explain why you need a deferral due to pregnancy as well as the date of your expected delivery:

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If approved, you will be expected to get a COVID-19 vaccine once the deferral period ends. Emory School of Medicine will determine the end date.

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I understand that my request for an exemption 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 ID # ______________________________

Print Name: _________________________________ Signature ___________________________________

Please upload completed form in the School of Medicine exemption application.