EMORY
UNIVERSITY
SCHOOL OF
MEDICINE

# COVID-19 Vaccination Requirement
# Request for Deferral

Employee Name: ____________________________ Employee ID #: ___________________________

Department:___________________________________________________________________________

Job Title: ___________________________________________________________________________

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**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 temporary exemption if truly necessary. Acknowledged ________

Even though I can receive the COVID-19 vaccine at no charge to myself, I want a temporary exemption from the 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_____________

**Please explain why you need a deferral. [This section must be completed]**

______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________

What is the time period/end date for the deferral request? ________________________________

**Please attach supporting documentation from a licensed healthcare provider supporting your request. This should include medical records with the reaction or other medical reason for the deferral and the anticipated duration of the need for deferral. Please submit your documentation with this completed form. Requests will not be considered without documentation.**

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**A signature from a licensed healthcare provider is required to validate a medical contraindication that defers the COVID-19 vaccine.**

Physician Signature/Date:

_______________________________________________________________

Physician Name (Please Print):

_______________________________________________________________

Physician Contact Phone Number: ____________________________________

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

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 into the School of Medicine exemption application.**