University HOSPITAL
Newark, NJ

Healthcare Provider Release for Medical Exemption to Required Immunization and Attestation

YOU MUST RETURN THE COMPLETED FORM NO LATER THAN _____ __, _____TO THE OFFICE OF CHIEF MEDICAL OFFICER. FAILURE TO PROVIDE A COMPLETE AND SUFFICIENT CERTIFICATION IN A TIMELY MANNER MAY RESULT IN THE DENIAL OF YOUR MEDICAL EXEMPTION REQUEST.

Employee: _____ Employee ID: _____
First Middle Last If available

My Mailing Address: _____

Telephone: _____

By my signature below, I demonstrate my informed consent and authorization to allow my healthcare provider to release, disclose and communicate to my employer or employer representative such healthcare records and information concerning my current medical condition(s) as is necessary to support my request for exemption from required immunization. I further authorize my employer or employer representative to contact my healthcare provider directly for the purposes of clarification and verification of the authenticity of this certification. This authorization shall be valid for one (1) year from the date shown below, unless revoked by me in writing at an earlier date. Although I understand that I may revoke this authorization in writing at any time, I also understand that any such revocation will not apply to any information that has already been released in reliance on this authorization. The information shall not be released to my immediate supervisor.

I hereby authorize my healthcare provider to complete and provide this certification form directly to my employer via fax or mail.

_____
Employee Name (print)

_____ _____
Employee Signature Date

PLEASE FAX, E-MAIL OR MAIL TO

Executive Director Quality and Patient Safety
University Hospital
150 Bergen Street
PO Box 27050
B Level, Room 261
Newark, NJ 07101-6750
Office: 973-972-2405 Fax: 973-972-1567
harrisj9@uhnj.org

UNIVERSITY HOSPITAL VACCINE MEDICAL EXEMPTION FORM
REQUEST FOR MEDICAL EXEMPTION FROM COVID-19 VACCINATION

PLEASE PRINT THE FOLLOWING INFORMATION:

Name:_____ Date of Birth:_____ / _____ / _____
E-Mail:_____ Phone/Pager No.:_____
Department:_____ Supervisor/Manager:_____
Physician Name:_____ Physician Phone No.:_____

Dear Physician:

University Hospital requires all healthcare personnel to be vaccinated against COVID-19. The patient named on this form is requesting an exemption from this requirement.

Please complete the form below. Should you have any questions, please contact University Hospital's Chief Medical Officer at 973-972-0440. Thank you.

The above patient should not be vaccinated for Covid-19 for the following reason(s):

I certify that my patient named above has a contraindication to the COVID-19 vaccine and ***request*** a medical exception. Please note that this request will be reviewed on a case-by-case basis.

Physician Signature: _____ Date: _____
(Note: Signature Stamp Not Acceptable)
Physician Medical License No.: _____

PLEASE FAX, E-MAIL OR MAIL TO

Executive Director Quality and Patient Safety
University Hospital
150 Bergen Street
PO Box 27050
B Level, Room 261
Newark, NJ 07101-6750
Office: 973-972-2405 Fax: 973-972-1567
harrisj9@uhnj.org

DESIGNATED OFFICE USE ONLY:
Medical Exception Approved on: _____ / _____ / _____Approving Staff Signature:_____

Must Complete Both Pages