University HOSPITAL
Newark, NJ

Healthcare Provider Release for Medical Exemption to Required Immunization and Attestation

YOU MUST RETURN THE COMPLETED FORM NO LATER THAN NOVEMBER 1st 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 exception to 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.

I hereby attest that I am required to wear a mask while on patient care units/areas or within three feet of patients for the duration of the influenza season as identified by the Office of the Chief Medical Officer. If I do not wear a mask, I may be subject to discipline up to and including termination.

_____
Employee Name (print)

_____ _____
Employee Signature Date

PLEASE FAX, E-MAIL OR MAIL TO

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

Must Complete Both Pages

University HOSPITAL
Newark, NJ

UNIVERSITY HOSPITAL VACCINE MEDICAL EXCEPTION FORM
REQUEST FOR MEDICAL EXCEPTION FROM INFLUENZA VACCINATION

PLEASE PRINT THE FOLLOWING INFORMATION:

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

Have you ever been granted a medical exception through Occupational Health? ☐YES ☐NO
If **YES**, please list years _____
If **NO**, please have provider complete below:

Dear Physician:

University Hospital requires influenza vaccination similar to other required vaccinations such as MMR and varicella. The above-named person is requesting an exception from this vaccination requirement. A medical exception from influenza vaccination is allowed for certain recognized contraindications.
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 person should not be immunized for influenza for the following reasons (Please check all that apply.):
☐ History of previous severe allergic reaction and documented allergy testing to indicate an immediate hypersensitivity reaction to the influenza vaccine or a component of the vaccine. **Please attach supporting DOCUMENTATION or MEDICAL RECORDS.**
☐ History of Guilain-Barre Syndrome within six weeks of receiving a previous vaccine. Please provide and attach a detailed narrative that describes the event.
☐ Other – Please provide this information in a separate narrative that describes the exception in detail (these requests will be reviewed on a case-by-case basis).
**A severe allergic reaction is characterized by a sudden or gradual onset of generalized itching or erythema (redness), hives; angioedema (swelling of the lips, face or throat); severe bronchospasm (wheezing); shortness of breath; shock; abdominal cramping; or cardiovascular collapse.*

By signing below, I affirm that I have reviewed the current e Advisory Committee on Immunization Practices (ACIP) Contraindications and Precautions (https://www.cdc.gov/vaccines/hcp/acip-recs/index.html) and that the stated contraindication(s)/precaution(s) is/are enumerated by the ACIP and consistent with established national standards for vaccination practices. I understand that I might be required to submit supporting medical documentation. I also understand that any misrepresentation might result in referral to the New Jersey State Board of Medical Examiners and/or appropriate licensing/regulatory agency.

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

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

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