REQUEST FOR MEDICAL EXEMPTION FROM COVID-19 VACCINATION

If you have a specific medical condition that precludes the COVID-19 vaccination requirement and you seek a medical exemption from LLNS's COVID-19 vaccination requirement, please consult with your physician and provide the following information. Once fully complete, the employee or employee's physician will email the completed form and any supporting documentation to ehr-scan@llnl.gov. The employee will then call 925-422-7462 to make an appointment with an HSD provider to discuss.

Please print the following information:

Name:_____ **Employee ID:** _____

Physician Name:_____ **Physician Phone No.:** _____

Physician Address: _____

Dear Physician:

Per direction from the U.S. Department of Energy, LLNS requires that all employees be vaccinated against the COVID-19 virus. Medical exemptions from vaccination may be granted on the basis of certain recognized contraindications. (https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html) The LLNL Health Services Division will evaluate exemption requests based on medical reasons other than recognized contraindications. A medical exemption must be based on a physician-identified contraindication or restriction, not on the doctor's conclusions about how any condition or restriction may or may not be accommodated in the workplace.

This employee should not be immunized against COVID-19 for the following reasons (Please check all that apply):

☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a component of the COVID-19 vaccine.

☐ Immediate allergic reaction of any severity to a previous dose or known (diagnosed) allergy to a component of the vaccine (Vaccine Ingredients: https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html#Appendix-C)

Which brand(s) of the COVID-19 vaccine is contraindicated? _____

How long will the medical contraindication last? _____

☐ Other Medical Reason – Please provide this information in a separate narrative that describes the other medical reason/restriction justifying an exemption from COVID vaccination or deferral in detail.

- ✓ Date condition began: _____
- ✓ Reason exemption is requested (please do not include diagnosis or potential accommodations):

_____

_____

- ✓ Anticipated duration of contraindication: _____

Physician Signature:_____ **Date:** _____

☐ Request approved Exemption

☐ Request not approved

Comments (if any): _____

LLNL Physician Signature:_____Date: _____

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(When Filled In)

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May be exempt from public release under the Freedom of Information Act (5 U.S.C. 552),
exemption number and category 6 - Personal Privacy, Department of Energy review required before public release.

Name/Org: _____ Date: _____ Guidance (if applicable): _____

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