NYC HEALTH + HOSPITALS

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COVID-19 Vaccine Medical Exemption Request

Section I.
To be completed by employee

Last Name	First Name	Facility	TKID #	Email

Section II.
To be completed by the staff member's health care provider

Dear Health Care Provider:

The staff member listed above has requested a reasonable accommodation based on medical reasons in place of receiving the COVID-19 vaccination. In the space provided below, please indicate:

a. Would COVID-19 vaccination be detrimental to the health of the person listed above? □ Yes □ No
b. If yes, does the person listed above have a specific pre-existing health condition? □ Yes □ No
c. What is the date of onset of the pre-existing health condition? _____
d. If the pre-existing health condition is temporary what is the earliest date by when the person listed above may receive the COVID-19 vaccine? _____

Please describe below in detail the reason the person listed above should receive an exemption from the New York State COVID-19 vaccine mandate, including the nature of the specific pre-existing health condition.

Revised 8.24.2021

CERTIFIED:
Signature of Health Care Provider: _____
Name of Health Care Provider: _____
Medical Specialty: _____
Date: _____
Phone Number: _____
Email Address: _____