UMMS non-employed provider: After the form below has been filled out by your treating medical provider, please visit [umms.org/NEVaxExemption](https://www.umms.org/covid-vax-non-employed-self-reporting/exemptions) to complete an online declination and to upload this completed Medical Exemption Form or other documentation from your medical provider.

|  |  |  |  |
| --- | --- | --- | --- |
| Employee Name |  | Email Address |  |
| UMMS Member Org. |  | Phone Number |  |

Dear Provider,

The University of Maryland Medical System (UMMS) and its member organizations require staff to be vaccinated with one of the COVID-19 vaccines, which have been shown to be safe and effective. Healthcare worker vaccination is critical to our fight against COVID-19. COVID-19 is highly contagious and an infected healthcare worker could unknowingly spread COVID-19 to vulnerable patients and other workers before realizing they are sick.

The above-named person is requesting an exemption from the UMMS Mandatory COVID-19 Vaccination Policy for medical reasons. If there is a medical contraindication or other appropriate medical reason why your patient cannot receive the COVID-19 vaccine, please complete the form below. Please note that signature, medical specialty and license number are required for approval.

**The above person should not be immunized against COVID-19 for the following reasons (Check all that apply):**

\_\_ History of previous allergic reaction suggestive of an immediate hypersensitivity reaction to the COVID-19 vaccine

or a component of the vaccine that would preclude the individual from receiving the vaccine. *If an individual has an allergy to one mRNA vaccine, then they should not receive the other mRNA vaccine unless the allergy is known to be specific to that one vaccine only*.

Please select the specific vaccine(s) that the employee cannot receive (check all that apply):

\_\_ **Pfizer** \_\_ **Moderna** \_\_ **Johnson & Johnson**

­­\_\_ Other. Please provide this information in a separate narrative that describes, in detail, the medical reason why this individual cannot receive the COVID-19 vaccine. Please specify which COVID-19 vaccines should not be received and why. **Note that your signature, license number and specialty, , along with the specific vaccines to which this applies, are required in order to approve this exemption.** These requests are reviewed on a case-by-case basis.

Provider Signature:

Medical Specialty:

Provider Medical License Number:

Date: