COVID-19 Vaccine Medical Exception Request Form

Instructions: If you are requesting an exception from the COVID-19 vaccination requirement for medical reasons you must fill out this form and **upload it to Human Resources** through the COVID Vaccination Reporting portal.

Individual's name:	Date of birth:
Phone number:	
Signature:	Date:
Employer/organization:	Job title/position:

Please note that if your exception request is approved, you may be required to take additional steps in the form of weekly testing, if legally mandated, to protect you and others from contracting and spreading COVID-19.

Please check an option below and complete related questions:

☐ Yes ☐ No   Is the medical condition temporary? If yes, what is the expected duration?

Please describe how this medical condition impacts their ability to receive the COVID-19 vaccination.

☐ The patient may not receive a certain type of COVID-19 vaccination. The patient may receive a vaccination manufactured by _____   .

☐ The patient may receive a COVID-19 vaccination.

I certify the above information to be true and accurate.

Printed name of medical provider:	Date:
Signature of medical provider:	Work address:
	Work telephone number:

Document accessibility: For individuals with disabilities or individuals who speak a language other than English, OHA can provide information in alternate formats such as translations, large print, or braille. Contact the Health Information Center at 1-971-673- 2411, 711 TTY or COVID19.LanguageAccess@dhsoha.state.or.us.