

COVID-19 Vaccine Medical Exception Request Form

I am requesting an exception from the COVID-19 vaccination requirement on the basis of a diagnosed physical or mental condition that limits my ability to receive the COVID-19 vaccination, as certified by my medical provider below.

Individual's name:	Date of birth:	
Phone number:	<u> </u>	
Signature:	Date:	
Employer/Organization:	Job Title/Position:	
Please note that if your exception request is approved, or other responsible party to take additional steps to preand spreading COVID-19. Workplaces are not required accommodation if doing so would pose a direct threat the workplace or would create an undue hardship. Statement from Medical Provider	otect you and others from contracting I to provide this exception	
Statement from Medical Provider		
Your patient, named above, has requested an exception requirement due to a medical condition. Please provide		
Please check an option below and con	nplete related questions:	
The patient should not receive the COVID-19 vaccination due to a medical condition.		
What is the medical condition that prevents them fro COVID-19 vaccination?	om receiving the	
☐ Yes ☐ No Is the medical condition permanent?		
☐ Yes ☐ No Is the medical condition temporary?	? If yes, what is the expected duration?	
Please describe how this medical condition impacts COVID-19 vaccination.	their ability to receive the	

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.