Name: Date of Birth: _____

Job Title: Job Location: _____

Email address: Phone number: _____

COVID-19 Vaccination Exemption Request

I am requesting an exemption from the COVID-19 vaccination requirement based on the following:

☐ Documented health-related contraindication. Please attach documentation from your treating health care provider (physician, advanced practice provider, CNP) to this form and have your treating health care provider complete the attached medical exemption form.

☐ Documented allergic reaction to an ingredient in the COVID-19 vaccine. Please attach appropriate documentation of the allergic reaction from your treating health care provider (physician, advanced practice provider, CNP) to this form and have your treating health care provider complete the attached medical exemption form.

☐ Documented history of allergic reactions to other vaccines or other medical injections. Please attach appropriate documentation of the allergic reaction to this form and have your treating health care provider (physician, advanced practice provider, CNP) complete the attached medical exemption form.

☐ Documented COVID-19 infection or a history of having received a COVID-19 monoclonal antibody infusion within 90-days prior to the December 3, 2021, deadline. NOTE: you will be eligible for a temporary exemption until after the end of the 90-day period and then required to receive a COVID-19 vaccination within 14-days of the end of the exemption.

☐ Religious (details required in next question).

Medical Exemption Form

Name of Practitioner: _____

Title: _____

Vaccines clinically contraindicated:

☐ Yes ☐ No

Recognized Clinical Reasons for Contraindication _____

_____

_____

_____

Documented allergic reaction to ingredient in COVID-19 vaccinations:

☐ Yes ☐ No

Documented Allergic Reaction: _____

Documented allergic reaction to other vaccinations or medical injections:

☐ Yes ☐ No

Documented Allergic Reaction: _____

I, _____ recommend that _____ be exempt from the Ohio Department of Veterans Services vaccination requirements based on the recognized clinical contraindications specified above.

_____ _____

Signature of Practitioner Date

** Please submit all documentation supporting your medical exemption request. If the documentation submitted does not contain sufficient information, you may be asked to provide additional information in support of your medical exemption request.

Religious Exemption Form

I, _____, am seeking a religious exemption from a Department of Veterans Services employment requirement because of my sincerely held religious belief described below.

Please identify the Department of Veterans Services requirement, policy, or practice that conflicts with your sincerely held religious observance, practice, or belief (hereinafter "religious beliefs"). _____
_____
_____
_____

Please describe the nature of your sincerely held religious beliefs or religious practice or observance that conflict with the Department of Veterans Services requirement, policy, or practice identified above. _____
_____
_____
_____
_____

What is the accommodation or modification that you are requesting? _____
_____
_____
_____

List any alternative accommodations that also would eliminate the conflict between the Department of Veterans Services requirement, policy, or practice and your sincerely held religious beliefs. _____
_____
_____
_____
_____

By signing below, I verify that the information is complete and accurate to the best of my knowledge, and I understand that any intentional misrepresentation contained in this request may result in disciplinary action, up to termination of employment. I understand that if I am granted a religious exemption, the fact that I have received a religious exemption may be shared with those at the Department of Veterans Services who have a need to know. I further understand that decisions made regarding exemption requests are final.

_____ _____
Signature Date