Immunization Exemption Request for Contingent Worker

Please submit completed form to your assigned department manager or RightSourcing Representative

Name (Print):_____ Facility Name:_____ Employer:_____

ACKNOWLEDGMENTS

It is expected that contingent workers receive required immunizations in order to protect themselves, its patients, workforce, and community.

- All Health workers (including non-clinical workers) are expected to receive the required vaccinations/immunizations indicated in the Intermountain Immunization Policy.
- Because I am a health care worker, I may transmit Pertussis (whooping cough), Measles (Rubeola), Mumps, Rubella, Varicella (chicken pox), Influenza and/or COVID-19 to my patients and other health care workers, as well as to my family and friends, even though I have no symptoms.
- If I become infected with Pertussis (whooping cough), Measles (Rubeola), Mumps, Rubella, Varicella (chicken pox), Influenza, or COVID-19, even if my symptoms are mild or not noticeable, I can spread severe illness to others, particularly to those in an Intermountain Health facility that are at high risk for disease complications.
- The influenza vaccination is required annually because the strains of influenza virus can change each year and because immunity weakens over time.
- The Influenza Exemption Request is only valid for one year; a new request must be submitted annually, unless otherwise notified.
- It is unknown whether COVID-19 vaccinations will be required annually. If I am approved for a COVID-19 vaccination exemption, I will be notified.
- If I am exempt from receiving a vaccination/immunization, I may be required to use personal protective equipment as recommended as identified by Intermountain Health Infection Control in addition to other measures such as testing that may be put in place. Failure to comply with these requirements will result in dismissal from my work assignment.
- In the event of an outbreak of a disease for which I have not been immunized, I may be taken off the work schedule until such time that conditions have changed, and I can return to work safely.

I have read the above information and am applying for an exemption by completing the required information on the right side of this form.

Worker Signature:_____ Date:_____

RELIGIOUS EXEMPTION

Please check the box next to the vaccination/immunization requirement from which you are seeking a religious exemption:

☐ Influenza ☐ MMR ☐ Tdap ☐ Varicella

Attach documentation describing, in your own words, what your sincerely held personal religious belief and/or religious tenet is and how it prevents you from receiving the vaccination/immunization requirement(s) checked above. A religious exemption must be based on a sincerely held personal religious belief or tenet. Political and/or philosophical beliefs cannot qualify for a religious exemption.

Worker Signature:_____ Date:_____

MEDICAL EXEMPTION

A primary care provider signature is required to validate a medical contraindication or precaution that does not allow for an immunization. Provider signatures can include MD, DO, or APP.

To be filled out by MD/DO or APP: In the space below, please answer **ALL** of the questions. Please be as specific as possible and provide as much detail/information as possible. For guidance on medical contraindications see the CDC/ACIP recommendations at: http://www.cdc.gov/vaccines/recs/vac-admin/contraindications.htm

Exemption requested for: ☐ Influenza ☐ MMR ☐ Tdap ☐ Varicella

1. Patient Name, DOB _____
2. Specific contraindication or precaution/medical condition*:
   - ☐ Allergy to neomycin or gelatin (MMR or Varicella vaccine ONLY)
   - ☐ History of myocarditis or pericarditis
   - ☐ History of Guillain Barré Syndrome
   - ☐ Contraindication to live virus vaccine – (MMR or Varicella vaccine ONLY)
3. Other acceptable conditions:
   - ☐ Undergoing infertility treatment
   - ☐ Pregnancy. Due Date: _____
   - ☐ Immunosuppression:
     Describe immunosuppression and its expected duration: _____
4. Date of the reaction/condition*: _____
5. Description of reaction* (list symptoms): _____
6. Time from vaccination to start of reaction: _____
7. Duration of symptoms: _____
8. Correlation of reaction to the vaccination*: _____

*Insufficient information or providing medical conditions which are not approved contraindications or precautions will result in request for further information and/or denial of exemption.

Primary Care Provider Signature:_____

Primary Care Provider Name (print):_____ **Degree**: _____

Practice Location (with city and state):_____

Date:_____ **Phone**:_____