UMass Memorial Health

INFLUENZA VACCINATION MEDICAL/DISABILITY EXEMPTION REQUEST FORM 2022

UMass Memorial Health ("UMMH") may provide a medical exemption from the annual mandated influenza vaccine if an employee or appropriate requesting individual (a "Requestor") has a medical contraindication to the influenza vaccine or they otherwise have a medical condition or disability that prevents them from receiving the influenza vaccine. Exemption requests will be maintained in a confidential manner by Employee Health Services, and will be reviewed by a diverse, multi-disciplinary, system-level committee with all personal-identifying information removed prior to submission to the committee. If an exemption is granted, Human Resources and the Requestor's manager will determine whether the Requestor can be offered a reasonable accommodation in their present or anticipated role if they remain unvaccinated.

Medical exemption approvals are based in part on CDC guidance regarding the potential for severe allergic reactions to the vaccines. A severe allergic reaction is one that needs to be treated with epinephrine or EpiPen or with medical care. An immediate allergic reaction means a reaction within four (4) hours of exposure, including symptoms such as hives, swelling, or wheezing (respiratory distress). Guillain-Barré syndrome occurring within six (6) weeks after receiving an influenza vaccination is also a reason for exemption

If you wish to request an exemption from the Influenza Vaccine Mandate due to a medical contraindication or other medical condition/disability, please sign the Requestor Statement below and have your licensed healthcare provider complete the requests that follow.

Once completed, please return this form to your entity's Employee Health Services Team. Exemption requests must be received no later than ***October 15, 2022*** *to be timely. All individuals mandated to be vaccinated against influenza must either have received an exemption or provided proof of influenza vaccination on or before December 15, 2022 or be subject to discipline/exclusion from UMMH premises.*

You will be notified in writing of the exemption review committee's decision related to your request.

Requestor Statement

Because of a medical contradiction to the Influenza vaccine or other medical condition/disability as described by my health care provider below, I request an exemption from the 2022 Influenza Vaccination required by UMMH.

I authorize UMMH to contact the healthcare provider identified below if additional information regarding my health status is necessary in order for UMMH to determine my eligibility for exemption/deferral and accommodation.

Requestor signature: _____ Date: _____

Requestor name (printed):_____ DOB: _____

Position: _____ Employing Entity: _____

UMass Memorial Health

Influenza Vaccine Mandate: Healthcare Provider's Certification for Exemption Request

Healthcare Worker Name_____

Dear Health Care Provider,

UMass Memorial Health (UMMH) and its affiliates are committed to providing a safe environment for all patients, workforce members and visitors. As influenza is a highly contagious and serious illness, all UMMH workforce members are required to receive an influenza vaccination each year or have an approved exemption. This includes non-patient facing/non-clinical roles, due to the potential for these individuals to spread infection to patient-facing/clinical roles during onsite meetings and interactions, and it includes certain remote roles with occasional on-site responsibilities as well.

The above-named individual is a UMMH employee or individual otherwise mandated to be vaccinated against influenza by UMMH and is also your patient. They have indicated that they have a medical contraindication to the influenza vaccine or that they have some other medical condition or disability that prevents them from receiving the vaccine. Please document the reasons this person's request should be considered below.

____Severe allergic reaction (anaphylaxis) to an influenza vaccine. If "yes", please provide details regarding the allergic reaction below, including which influenza vaccine the individual received, inpatient or outpatient care/treatment resulting from the influenza vaccine allergic reaction, dates, and details regarding whether the individual would be able to take a different influenza vaccination.

_____
_____
_____

_____Other medical reason or condition. Provide details about the other medical condition including how the condition prevents the individual from receiving an influenza vaccine, the specific influenza vaccine the individual is unable to receive, and whether the individual can receive a different type of influenza vaccine.

_____
_____
_____

Provider: By signing below you are attesting that the individual is a patient of yours and that based on your medical judgment and expertise the above-named individual is unable to receive an influenza vaccine. If necessary, you may be contacted with follow-up questions so that UMMH may fully consider whether this individual can be afforded an exemption as a reasonable accommodation.

Provider Signature: _____Date: / /_____

Provider Printed Name: _____

Work Address & Phone:_____

Please fax this completed form to 508-334-6433.