VitalCare

MANDATORY INFLUENZA VACCINATION PROGRAM
EXEMPTION REQUEST FORM

Name: _____

Phone: _____

Role: _____

Supervisor: _____

I request an exemption to the VitalCare Corporation Mandatory Influenza Vaccination requirement based on the following:

_____ MEDICAL CONTRAINDICATION (DOCUMENTATION REQUIRED)
_____ NON-MEDICAL EXEMPTION REQUEST

I understand that my failure to submit a completed Exemption Request Form, including for example, acceptable medical documentation for a medical exemption, before the end of the Designated Vaccination Period may result in my request for an exemption being denied.

My signature on this form is my attestation that I am requesting an exemption in good faith, and the information I am providing or causing others to provide on my behalf is true and correct. I understand that providing false or misleading information may be grounds for discipline, up to and including discharge.

I understand and consent to the following:

- My exemption request will be reviewed by the Agency Administrator.
- My manager and/or supervisor may be consulted as part of the exemption review process.
- My manager and/or supervisor will be notified if my exemption request is granted.
- My exemption may not be granted if it would pose a direct threat to others (i.e., patients, co-workers or visitors) or if it would otherwise create an undue hardship on VitalCare.

Signature: _____ Date: _____

DESIGNATED OFFICE USE ONLY:

Medical Documentation Received on: (DATE) _____

□ Approved (DATE)_____

□ Denied (DATE)_____

Reason for Denial _____

Religious/Personal Exemption Request Received on: (DATE)_____

□ Approved (DATE) _____

□ Denied (DATE) _____

Reason for Denial_____

Manager and Associate Notification: _____

Approving Signature: _____ DATE: _____

VitalCare

MANDATORY INFLUENZA VACCINATION PROGRAM
MEDICAL PROVIDER CERTIFICATION OF EXEMPTION FORM

Patient Name: _____

Patient DOB: _____

I _____ give permission for my healthcare provider to complete this form and provide the requested information concerning my medical condition that prevents me from receiving an influenza vaccination to the office listed below:

Signature: _____ Date: _____

Dear Primary HealthCare Provider,

VitalCare requires an annual influenza vaccination for all employees. Your patient is requesting an exemption based on his/her medical contraindications. In order for VitalCare to review the request, we will require the following medical information from you:

1. Acceptable reasons for exemption from flu vaccine (please check one):
   - □ Severe documented egg allergy
   - □ Documented allergy to any vaccine component
   - □ Severe documented reaction to a previous influenza vaccine
   - □ History of Guillain-Barré Syndrome

2. Please provide the medical diagnosis that would preclude administration of an annual influenza vaccine. ***Describe the nature, duration and severity of the medical condition and provide copies of office notes, allergy testing and any other documentation to support the exemption.***

3. Provide an explanation as to why the medical condition prevents your patient from receiving the influenza vaccine

4. If the reason for exemption is due to pregnancy or lactation, please provide an explanation of why CDC recommendations for annual influenza should not be followed for your patient.

5. Please provide any suggested reasonable alternatives to the influenza vaccine that you consider appropriate for your patient.

Provider Name: _____

Provider Phone: _____

Provider Address: _____

Provider Signature: _____

RETURN TO: VitalCare Corporation
OR email to info@vitalcare.us **OR** fax to 720-815-3372

VitalCare

MANDATORY INFLUENZA VACCINATION PROGRAM
CLIENT ACKNOWLEDGEMENT OF PCW EXEMPTION

Client Name: _____

Client Address: _____

Client Exclusive PCW Name: _____

PCW Relationship to Client: _____

PCW Address: _____

I understand that influenza is dangerous and could result in hospitalization and sometimes death. Pneumonia, bronchitis, sinus infections and ear infections are examples of flu-related complications. Flu also can make chronic health problems worse. For example, people with asthma may experience asthma attacks while they have flu and people with chronic congestive heart failure may experience a worsening of this condition triggered by flu.

I understand and acknowledge that my Client Exclusive Personal Care Worker (PCW) has been granted an exemption to VitalCare's mandatory influenza vaccination program per my request. I understand and acknowledge that I am at a greater risk of acquiring influenza because my Client Exclusive PCW is not vaccinated against the flu.

VitalCare requires all employees who have been granted an exception to the mandatory influenza program wear a mask at all times when working with a client on behalf of the agency during the flu season. The flu season runs approximately October 01, through March 31 annually. However, this period can be adjusted by the Center for Disease Control depending on the severity of the flu season.

VitalCare recognizes that Client Exclusive PCW's often live with or are part of the clients extended family and or community and they find it is unnecessary for the Client Exclusive PCW to wear a mask when working with the client as an employee for VitalCare during the flu season.

I understand and acknowledge that if I choose to allow my Client Exclusive PCW not to wear a mask during Flu season, I am placing myself at even greater rick of acquiring influenza.

Please acknowledge your preference for Mask usage during the flu season for your Client Exclusive PCW.

_____ **I WANT MY CLIENT EXCLUSIVE PCW TO WEAR A MASK DURING THE FLU SEASON**

_____ **I DO NOT WANT MY CLIENT EXCLUSIVE PCW TO WEAR A MASK DURING THE FLU SEASON**

Client or Representative Signature: _____ Date: _____

I acknowledge and agree to comply with the Client's Mask usage preference during the flu season.

Client Exclusive PCW Signature: _____ Date: _____