STILLWATER MEDICAL

Medical or Religious Waiver to Decline COVID Vaccine

PRINT NAME_____ BADGE #_____

MEDICAL WAIVER–I certify that the above person is under my medical care and should be exempt from receiving the COVID vaccination due to a prior severe, allergic reaction to the COVID vaccination or components of the COVID vaccination

_____ _____

MD, DO, ARNP, PA (PRINT) Date

_____ _____

MD, DO, ARNP, PA (SIGNATURE) Phone Number

_____

Address

_____

RELIGIOUS WAIVER–It is my sincerely held religious belief to not be vaccinated for COVID.

_____ _____

Name (PRINT) Date

_____

Name (SIGNATURE)

I agree to abide by the following:

When in designated “high risk” per policy, the minimum PPE required that I wear is a PAPR or N95 respirator (if fit tested within the last 12 months) at all times and I will wear eye protection for all patient interactions.

_____ _____

Signature Date