Faithful Home Care Solutions

Application for Medical Exemption from COVID-19 Vaccination

Name: _____

Faithful Home Care Solutions ID (If applicable): _____

Email Address: _____

Phone Number: _____

Instructions for Submission of Application for Medical Exemption from COVID-19 Vaccination:

Please have your medical provider complete and sign the Healthcare Provider Section and Verification portion of this form and submit the completed form to our website at faithfulhomecare.com under Covid-19 information (Medical Exemption Form).

The medical information that you provide on this form will be kept confidential. Your application will be reviewed, and you will receive a message from your employer notifying you of their decision. If your request is granted, you will be marked as compliant with the state requirement.

However, you will be required to comply with any applicable COVID-19 mitigation protocols for individuals who are not fully vaccinated, including facial coverings, weekly testing (**PCR** testing), and completion of the daily self-assessment. Details regarding current protocols will be sent via email.

Attestation:

Signing this application, I am requesting a medical exemption from vaccination for COVID-19 required by Faithful Home Care Solutions for all employees. By signing this application, I understand that, for the safety of the client, I will be required to comply with Faithful Home Care Solutions' COVID-19 mitigation protocols as outlined in our original correspondence sent on September 28, 2021.

_____ Date: _____

Signature

_____ Date: _____

Printed Name

Healthcare Provider Section and Verification:

A licensed physician, physician's assistant, or nurse practitioner must complete the medical exemption statement and provide their information below. Forms completed by the employee seeking the exemption will not be accepted.

Healthcare Provider Instructions: Completing this form verifies that the following medical contraindication precludes vaccination for COVID-19.

Name of Person Seeking a Medical Exemption from COVID-19 Vaccination

(Printed): _____

Provide a detailed explanation of the specific medical contraindication requiring a COVID-19 vaccine exemption:

_____

_____

_____

I hereby certify that the above-named patient qualifies for a medical exemption from COVID-19 vaccination and that the medical contraindication is well-documented in their health record.

Signature of Healthcare Provider: _____

Date: _____

Printed Name: _____

Email: _____

Phone: _____

Practice Address: _____