OUR PATIENTS.
OUR PEOPLE.
OUR STEWARDSHIP
OUR PURPOSE.

Request for Immunization Exemption

I am requesting a medical exemption from receiving (indicate which and complete page 1 & 2):

☐ Influenza vaccine

☐ COVID-19 vaccine(s)

☐ Other vaccine: _____
Name of vaccine

☐ Tuberculin Skin Test

I have a medical condition that prevents me from getting the vaccine.

I do hereby affirm that the information provided by my medical professional is true, accurate and complete.

I do hereby affirm that I recognize I am required to use personal protective equipment (PPE), comply with testing requirements as outlined in COVID-19 Policies and as directed by the Agency, and understand that if I am not compliant, performance improvement, progressive discipline may be issued.

Attachment A (second page) must be completed or reproduced on letterhead from your medical professional (must be MD or DO).

_____ _____
Employee Name Employee ID Number

_____ _____
Telephone Number Email Address

_____ _____
Employee Signature Date

MEDIC
Medical Excellence. Compassionate Care.
Mecklenburg EMS Agency
4425 Wilkinson Blvd
Charlotte NC 28208
p 704-943-6000
f 704-943-6001

medic911.com

Request for Immunization Exemption

Attachment A - Please have your provider complete the below or use this attachment for reproduction on letterhead (MD or DO).

Name of Individual Requesting Medical Exemption: _____

Employee #: _____

Mecklenburg EMS Agency may recognize exemptions to the following vaccination(s) for medical reasons (indicate which):

☐ Influenza vaccine

☐ COVID-19 vaccine(s)

☐ Other vaccine: _____
Name of vaccine

☐ Tuberculin Skin Test

The individual identified above is requesting to be exempt from the vaccination(s) for medical reasons. The employee has a medical contraindication that would prevent them from receiving the vaccination(s) and qualify for an exemption by completing the information below.

My patient has a contraindication that warrants a medical exemption from the _____ (name of vaccine) vaccine. I do hereby attest that this medical exemption is based upon true and accurate medical information that I have as this individual's medical provider. I understand that I could be contacted for additional clarification.

_____ _____
Provider Name (Please Print) MD DO (circle one) License #

_____ _____
Provider Signature Date

_____
Provider Location (Street Address)

_____
Provider Location (City) (State) (Zip)

_____
Provider Telephone Number

PG. 2

OUR PATIENTS.
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Request for Immunization Exemption

I am requesting a religious exemption from receiving (indicate which):

☐ Influenza vaccine

☐ COVID-19 vaccine(s)

☐ Other vaccine: _____
Name of vaccine

☐ Tuberculin Skin Test

As described below, my religious beliefs prevent me from receiving the listed vaccine(s).

Please provide statement regarding your request for a religious exemption.

I attest:

_____

_____

_____

_____

I do hereby affirm that the above information reflects my religious beliefs and is true, accurate and complete.

I do hereby affirm that I recognize I am required to use personal protective equipment (PPE), comply with testing requirements as outlines in COVID-19 Policies and as directed by the Agency, and understand that if I am not compliant, performance improvement, progressive discipline may be issued.

I understand that additional information may be requested after receipt of my attestation.

_____ _____
Employee Name Employee ID Number

_____ _____
Telephone Number Email Address

_____ _____
Employee Signature Date

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