I am requesting an exemption from receiving:

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Mecklenburg EMS Agency

4425 Wilkinson Blvd

Charlotte NC 28208

p 704-943-6000

f 704-943-6001

medic911.com

Influenza vaccine  COVID-19 vaccine(s)  Other vaccine: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of vaccine

I have a medical condition that prevents me from receiving the vaccine(s).

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

I am requesting a religious exemption from vaccination(s). I understand that this exemption is allowed solely for sincerely held religious beliefs and not for political, social, or other personal views.

*Statement of religious objection to the vaccine required:*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

By signing and submitting this form, I am acknowledging that I will not have the protection afforded by the vaccines and therefore knowingly agree to don personal protective equipment (PPE)as required by Agency policy. I agree to comply with testing requirements where applicable and as directed by the Agency, I also understand that if I am not compliant, performance improvement, progressive discipline may be issued.

I verify that the information I am submitting to substantiate my request is true and accurate.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name ID Number

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee Signature Date

**Pg. 1**

*Attachment A –* A physician (M.D. or D.O) licensed to practice medicine in North Carolina or South Carolina must complete and sign this form.

Employee Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employee #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I certify that my patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_has a contraindication that prevents them from receiving certain vaccination(s) and is requesting to be exempt from the following vaccination(s) for medical reasons.

Influenza vaccine

COVID-19 vaccine(s)

Other vaccine: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of vaccine

Date exemption ends or the length of time the exemption will apply for the individual: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. If not indicated, this exemption will apply for a 12-month period.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Name (Print) MD DO (circle one)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Telephone Number

**PG. 2**



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