Influenza Vaccination Medical Exemption Request

Please print legibly

Section 1: Employee

Employee's Last Name:	**Employee's First Name:**	
Employee ID #:	**Month/day of Birth:**	**Phone #:**
Employee last 4 digits of SSN#	**Which McLaren subsidiary are you onboarding or working for:**	
Email Address Where Status of Exemption Request May Be Sent:		
Please check one: ❑ Employee, Including Employed Physicians ❑ Provider Not Employed By McLaren ❑ Volunteer ❑ Other:		

McLaren requires influenza vaccinations for all employees working/volunteering for McLaren except in the case of McLaren-approved exemptions conferred as a result of documented medical contraindication. If you believe that you have a medical reason that prevents you from receiving the influenza vaccine, you must submit this form, completed by your medical provider. The exemption form will be reviewed by the System Influenza Exemption committee which is comprised of healthcare professionals. McLaren reserves the right to confirm the information provided with your healthcare provider. By signing this form, you hereby authorize McLaren health professionals from the exemption committee to contact your medical provider regarding conditions that prevent you from receiving the influenza vaccination. If your request is approved, you will be medically exempted from receiving influenza vaccine with McLaren and you will be required to wear a mask while at any McLaren location when you are within 6 feet of a patient/client during influenza season. If your request is not approved, you will be required to receive the influenza vaccine.

I hereby authorize McLaren Health System to confirm my compliance with the Influenza Immunization Policy. The specific reason for requesting an exemption will not be disclosed to my manager/supervisor.

Employee Signature_____ **Date** _____

_____

WHAT PAPERWORK DO I NEED?

This *Influenza Vaccination Medical Exemption Request form.*
You, the employee, should complete Section above, and take the form to your healthcare provider (MD, NP, or PA).
Your healthcare provider should complete Section 2 and provide you with **supporting documentation at the time of your visit.**

Supporting documentation:

a. The medical documentation demonstrating a history of Guillain-Barre Syndrome (GBS) within 6 weeks of a previous dose of influenza vaccine (IIV or LAIV), severe, life threatening allergy to previous influenza vaccine or vaccine components, or other medical condition that would prevent you from safely receiving a vaccine.
b. Medical record/s with documentation must be provided along with your application form. Please retrieve and attach copies of your medical record (progress notes, visit notes, ED notes) to support the information on your application form.
c. **Please note that History of egg allergy alone will not be accepted as a reason for a medical exemption, as egg free influenza vaccines are available. Please contact local employee health with questions.**
d. Please note that McLaren influenza vaccines do not contain mercury or thimerosal.
e. Pregnancy absent other factors is an indication, not a contraindication to influenza vaccination.
f. McLaren does not utilize live influenza vaccination for staff. With this in mind being immunocompromised absent other factors is an indication, not a contraindication to influenza vaccination.

WHERE DO I SEND MY APPLICATION?

The completed forms and all required supporting documentation must be emailed to: employee.health@McLaren.org
***Please note: Page 1 and Page 2 must be filled out and submitted**

MY APPLICATION WAS DENIED. HOW CAN I APPEAL?

- An employee who is denied a request for a medical exemption can appeal in writing within 10 business days of written denial notification.
- The letter of appeal should be submitted to employee.health@McLaren.org

WHO DO I CONTACT FOR MORE INFORMATION?

Questions regarding MEDICAL exemptions should be emailed to employee.health@McLaren.org

Created by: Corporate Director Employee Health
Date created: 8/31/2022

McLaren

Influenza Vaccination Medical Exemption Request

Section 2: Medical Provider

Your patient is requesting a medical exemption from this vaccination. **Medical exemption from influenza vaccination is allowed ONLY for recognized contraindications.** Please complete the information below regarding your patient's request for a medical exemption.

Step 1: I am requesting a medical exemption from the influenza vaccination requirement for my patient based on:
NOTE: There is an egg, thimerosal, preservative, antibiotic, and latex free vaccine available

❑ **Previous severe reaction to influenza vaccine, please include medical documentation such as chart notes**
(i.e., severe, life threatening allergic reaction after previous does of influenza vaccine)

- The above does not include sensitivity to the vaccine such as an upset stomach or mild to moderate local reactions such as soreness, redness, itching, or swelling at the injection site.
- The above does not include subsequent upper respiratory infection or low-grade or moderate fever following a prior dose of the vaccine.

Date of reaction: _____ Description of reaction: _____

_____

_____

_____

_____

❑ **History of Guillain-Barre Syndrome (GBS) within 6 weeks of a previous dose of an influenza vaccine**
Date patient had GBS: _____ Date patient received influenza vaccine: _____

_____

_____

❑ **Other –** Please provide this information in a separate narrative that describes the exception in detail (these requests will be reviewed on an individualized basis)

Step 2: Complete the following and provide office notes supporting the request.

Describe the patient's symptoms and the treatment provided:

_____

_____

_____

_____

_____

_____

Step 3: Complete the following - *unsigned forms will be returned to employee for completion*

Licensed Medical Provider's Signature: **(Signature stamps will not be accepted.)** **Date:**	
Licensed Medical Provider's Name (Please print):	
Medical Provider's Address:	**City/State/Zip Code:**
Medical Provider's Phone #:	**Medical Provider's Fax:**

Note: Final determination will be made by the System Influenza Exemption Review Committee.

Attention Provider and Employee - ATTACH MEDICAL RECORDS

Please attach medical records or progress/visit notes that specifically indicate the contraindication/s for the patient receiving the Influenza vaccine. **Please note that the entire patient chart is not required -** only the ***progress/visit note*** of the healthcare provider ***demonstrating contraindications to the Influenza Vaccine is required.***

Created by: Corporate Director Employee Health
Date created: 8/31/2022