Sierra View Medical Center Required COVID-19 Vaccination Medical Exemption Request Form

First Name (Print):____________________Last Name (Print):______________________________Date______________________

Position:____Department: ____

Telephone Number:___________________________________

The State of California, Public Health Order has mandated all healthcare workers to receive a COVID-19 vaccination.

Sierra View Medical Center (SVMC) is committed to providing equal employment opportunities without regard to any protected status and a work environment that is free of unlawful harassment, discrimination, and retaliation. SVMC is committed to complying with all laws protecting employees' with Medical Disabilities and needed accommodations.

I request an exemption to the COVID-19 immunization requirement based on medical condition(s). I understand that my failure to submit acceptable medical documentation as stated below may result in my request for an exemption being denied. I further understand that my request for an exemption will be reviewed, and I will be contacted with a decision regarding my exemption request.

If I receive an exemption, I understand that in order to maintain a safe work environment for patients and staff:

- My Leader(s) will be notified of my exemption
- I will be required to wear a hospital issued surgical mask at all times, unless working in an area that dictates the necessity to wear a N-95
- It is my responsibility to be tested for COVID-19 on a weekly basis through the workforce testing process. Weekly frequency will be determined by employee status and schedule

I consent to the release of this request to all such representatives of Sierra View Medical Center, on a need-to-know basis, in order for the representatives to carry out their duties and to act on my request for an exemption.

Signature:____Date: ________________________

Physician Documentation

Dear Physician: Please complete the form below to request medical exemption for your patient. If you have any questions, please contact Sierra View Medical Center, Brooke Brown- HR Manager, (559) 788-6071.

I have evaluated and can verify that________________________ qualifies for the medical exemption. (Please do not describe the underlying medical condition or disability) and requests exemption from the COVID-19 vaccine. This patient's probable duration for inability to receive the vaccine is ________________. (If duration is unknown or permanent, so indicate)

Name of Physician (Primary Care Provider):____Telephone #: __________________

Signature:____ Date: ____________________________

Forward completed form and documentation by August 30, 2021 to: *Sierra View Medical Center, Brooke Brown – HR Manager at BBrown@sierra-view.com (email)* ***or*** *559-791-4712 (fax)*

FOR HUMAN RESOURCES USE ONLY

Date Received by Human Resources: ___________________ **Date Reviewed by Human Resources:** ____________________________

Signature of Reviewer: ____

Approved **Denied**