| Weill Cornell Medicine<br><br>**Request for Medical COVID-19 Immunization Accommodation Form** | Employee Name | WCM CWID |
|---|---|---|
| | Direct/Mobile Phone | Date of Birth |
| | Email<br>@med.cornell.edu | Job Title |

**INSTRUCTONS**: Weill Cornell Medicine requires that all faculty, staff, and volunteers receive a COVID-19 vaccination. A medical accommodation may be granted upon receipt of a completed form (below) not more than 6 months old, signed and certified by a licensed healthcare provider, not related to the submitter, and whose specialty is appropriate to the associated condition. **Weill Cornell Medicine faculty, staff, and volunteers must submit completed medical accommodation request forms to NYP Workforce Health & Safety at: WHSDataManagement@nyp.org.**

Medical accommodations expire when the medical condition(s) contraindicating COVID-19 immunization changes in a manner that permits immunization, as determined by Workforce Health & Safety in reviewing the request. The assigned expiration is at the sole determination of NYP/WCM.

Individuals with an approved accommodation may be required to comply with additional testing and other preventive requirements. After your request has been reviewed and processed, you will be notified, in writing, whether an accommodation has been granted or denied. If the approved accommodation contains an expiration, you will be expected to complete the vaccination requirement at that time. Should the condition continue, or a new immunization contraindication occur, a new request with updated documentation is required.

## To Be Completed by WCM Employee:

**By signing below**, I authorize Workforce Health & Safety to contact my healthcare provider to discuss my medical condition related to this request, if necessary.

**Employee's Signature**:_____ **Date:** _____

☐ By checking this box and typing my name above or signing with my digital ID, I am electronically signing this form.

## To Be Completed by Your Physician:

**Attention Health Care Provider:** Weill Cornell Medicine requires that all faculty, staff, and volunteers receive a COVID-19 vaccination.

_____ (insert patient's name) is requesting a medical accommodation from this vaccination requirement. A medical accommodation may be allowed for certain recognized contraindications. Please certify below the medical reason that your patient should not be immunized for COVID-19 by completing this form and attaching available supporting documentation. Information provided on this form will be reviewed by Workforce Health & Safety in consideration of the accommodation request.

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**Option 1 - Allergy**

☐ A documented history of a severe allergic reaction to any component of a COVID-19 vaccine or to a substance that is cross-reactive with a component. Please indicate which of the following vaccines are contraindicated and name the components, by vaccine. NOTE: since egg-free vaccine is available, history of egg allergy will not be accepted as a routine medical accommodation.

• Moderna - List the component(s): _____

• Pfizer - List the component(s): _____

• Janssen/Johnson & Johnson - List the component(s): _____

☐ A documented history of a severe allergic reaction after a previous dose of the COVID-19 vaccine.

Please indicate to which vaccine the patient had a reaction, and the date of the vaccine and reaction.

• Moderna - Date of Vaccine & Reaction: _____

• Pfizer - Date of Vaccine & Reaction: _____

• Janssen/Johnson & Johnson - Date of Vaccine & Reaction: _____

**Option 2 – Physical Condition/Medical Circumstance**

☐ The physical condition of the patient or medical circumstances relating to the individual are such that immunization is not considered safe. Please state, with sufficient detail for independent medical review, the specific nature and probable duration of the medical condition or circumstances that contraindicate immunization with the COVID-19 vaccine:

**Option 3 - Other**

☐ Other. Please provide this information in a separate narrative that describes, in detail, the medical condition or disability in detail that you opine would exempt this individual from vaccination:

Explanation:

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**Health Care Provider Certification**

I certify that _____ (patient name) has the above contraindication and support the request for a medical accommodation from the COVID-19 vaccine requirement at Weill Cornell Medicine.

**Provider Information**

| | |
|---|---|
| Medical Provider Name | |
| Medical Provider Specialty | |
| Medical Provider Signature | |
| Medical Provider License Number | |
| Date | |
| Name of Medical Provider's Company | |
| Email | |
| Phone Number | |