



# VCU

VIRGINIA COMMONWEALTH UNIVERSITY

## REQUEST FOR MEDICAL EXEMPTION FROM INFLUENZA VACCINATION\*

(Completed forms must be e-mailed to [emprel@vcu.edu](mailto:emprel@vcu.edu) no later than Friday, December 18, 2015.  
Forms received after this date will not be considered for an exemption in 2015.)

### TO BE COMPLETED BY VCU EMPLOYEE AND SENT TO HIS/HER TREATING PHYSICIAN (please print clearly):

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
E-mail address: \_\_\_\_\_ Office Phone #: \_\_\_\_\_ Cell phone #: \_\_\_\_\_  
Department: \_\_\_\_\_ Supervisor/Manager: \_\_\_\_\_

**Please sign and date the form at the acknowledgement section at the bottom before you send to your treating physician.**

Dear Treating Physician:

Virginia Commonwealth University Health System Authority aka MCV Hospitals and MCV Associated Physicians (collectively "VCU Health") requires influenza vaccination for all of its team members, contract and vendor staff. For decades, influenza vaccination has been recommended for healthcare workers because vaccines have been shown to be effective in reducing the incidence of influenza in inpatient populations. Influenza vaccination has also been recommended in pregnancy by the Centers for Disease Control (CDC) and Prevention to protect pregnant women (who are at increased risk of severe disease) and to protect the baby after it is born. Further, the requirement for flu vaccine has been noted as a best practice and is one that many peer institutions have implemented. Our goal is to prevent the flu for our patients, as well as our team members and their family members, and we have determined that mandating flu vaccine is essential to this effort.

### TO BE COMPLETED BY THE TREATING PHYSICIAN (PLEASE PRINT):

I understand that my patient is requesting an exemption from a vaccination requirement, and that a medical exemption from the influenza vaccination is allowed for certain recognized contraindications (refer to <http://www.cdc.gov/mmwr/pdf/wk/mm60e0818.pdf>).

[As the treating physician for this patient, please complete the sections below. If you have any questions, please contact VCU Employee Health Services at (804) 828-0584.]

**My patient should not be immunized for influenza for the following reasons (please check all that apply and please attach supporting DOCUMENTATION or MEDICAL RECORDS for any/all of the reasons you have selected):**

- ☐ History of previous allergic reaction and **documented allergy testing** to indicate an immediate hypersensitivity reaction to the influenza vaccine or a component of the vaccine.
- ☐ History of Guillain-Barre Syndrome within six weeks of receiving a previous vaccine. (Clinical documentation is required).
- ☐ Other (please describe and attach documentation): \_\_\_\_\_

I certify that \_\_\_\_\_ has the above contraindication(s) and request a medical exemption from influenza vaccination.

Treating Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Note: Signature Stamp Not Acceptable)

Treating Physician Medical License #: \_\_\_\_\_ Office #: \_\_\_\_\_

**PLEASE SCAN AND E-MAIL THIS COMPLETED FORM NO LATER THAN FRIDAY, DECEMBER 18, 2015 TO:**  
[emprel@vcu.edu](mailto:emprel@vcu.edu)

### VCU EMPLOYEE ACKNOWLEDGEMENT

\*By completing this form, I give permission for VCU Health to discuss my medical information with my treating physician. I acknowledge that, if an exemption is approved, I may be reassigned to a different work location or job duties based on my competencies and the patient population served at the discretion of management (please note that reassignment is not guaranteed and patient needs will be considered at all times). I further acknowledge that, if I am not allowed to work due to my failure to receive the vaccine, I understand that I must use any accrued leave that I have available to provide for pay continuation or the period of absence will be without pay. I certify that the information that I have provided is accurate and any misrepresentation may result in disciplinary action up to and including termination.

\_\_\_\_\_  
VCU Employee Signature

\_\_\_\_\_  
Date

### DESIGNATED FOR USE ONLY BY VCU EMPLOYEE HEALTH SERVICES:

Medical Exemption approved on: \_\_\_\_/\_\_\_\_/\_\_\_\_ Approving Staff Signature: \_\_\_\_\_