COVID-19 Mandatory Vaccine Reporting Requirement
Medical Exemption Certification Form
To be completed by the Employee's Medical Provider*

Employee Name:_____ **DOB:** _____

Attention Medical Provider

***Requests must be completed by a licensed physician, physician assistant or nurse practitioner**

The City of Newport News COVID-19 Mandatory Vaccine Reporting Requirements Policy requires all city employees to either disclose or decline to disclose their vaccination status, be fully vaccinated by September 30, 2021, or submit to weekly COVID-19 testing unless granted a medical or religious exemption from receiving the vaccine and/or provided medical documentation specifically exempting them from COVID-19 testing. Unless a physician specifically states that the employee is exempt from testing, the employee will be subject to weekly testing. Face coverings must be worn 100% of the time while at work for those employees subject to weekly testing. The above-named employee is requesting a medical exemption from the vaccine reporting requirement. **Exemptions will be authorized for one year from date of medical provider's signature.**

Please complete the form below. Should you have any questions please contact the Department of Human Resources at 757-926-1800 or HRCOVID19@nnva.gov.

I certify that for the reason(s) below, this employee should be exempted from the provisions outlined above:

☐ History of previous allergic reaction to indicate an immediate hypersensitivity reaction to a component of the vaccine.

☐ The physical condition of the individual or medical circumstances relating to the individual are such that immunization is not considered safe. Please indicate the specific nature and probable duration of the medical condition or circumstances that contraindicate immunization with the COVID-19 vaccine.

☐ Confirmation of pregnancy or pregnancy-related medical condition – Please provide due date and any other related documentation including postpartum requirements.

☐ Other (Medical Provider comments are required)

Medical Provider's comments:

_____

_____

_____

Medical Provider's Signature:_____ **Date:** _____

Medical Provider's Printed Name: _____

Provider's Address: _____

Provider's Phone Number: _____

Stamped signatures will not be accepted.