UHealth
UNIVERSITY OF MIAMI HEALTH SYSTEM

UNIVERSITY OF MIAMI
MILLER SCHOOL
of MEDICINE

Influenza Vaccination Medical Exemption Request Form
for **Non-Employees**
Submit to Flu@miami.edu

Please note that Employees should submit their application for Medical Exemption through Workday at http://workday.miami.edu. This form is for non-employees only.

Instructions and Information:
The mandatory Influenza (flu) Vaccination Policy reinforces the University's commitment to safety and provides consideration for a MEDICAL exemption to anyone who is unable to receive the vaccine for a verifiable MEDICAL reason. **To complete this application:**

1. Please complete Section 1.
2. Please print the **Healthcare Provider Form below (Section 2)** and provide it to your healthcare provider.
3. Please **request medical records** that support your request for a medical exemption at the time of your visit.
4. Attach medical records that support your request for a medical exemption to the application.
5. Submit this completed application (Sections 1 & 2 and medical records) to flu@miami.edu.

Where do I send my application?
Submit to the Employee Health Office at flu@miami.edu.

My application was denied. How can I appeal?
An individual who is denied a request for a MEDICAL exemption can appeal in writing **within three (3) business days of written denial notification**. The letter of appeal should be submitted to flu@miami.edu.

Who do I contact for more information?
Please contact the Employee Health Office at 305-243-3267 or email flu@miami.edu.

INSTRUCTIONS:

Section 1 to be completed by the applicant; Section 2 to be completed by the healthcare provider.

Please note that self-completed Healthcare Provider forms will not be accepted.

Section 1 (To be completed by the applicant)

Name:(Last)	(First)	C# or Workday#
Email:	Personal Phone #	
Department Name:	Job Title or Position:	
Supervisor Name:	SUPERVISOR Phone #	
Work Address:	Building Name:	Room#

Please answer the following questions (enter n/a if not applicable):

1. Did you RECEIVE the Flu Vaccine last year? _____
2. Where did you receive the vaccine last year? _____
3. If you received the Flu Vaccine last year, did you have any of the following untoward reactions? Please check below and attach supporting documentation.
   - [ ] Anaphylaxis
   - [ ] Guillain-Barré Syndrome
   - [ ] Other Severe Reaction
     - Please specify reaction: _____
4. If you did NOT receive the Flu Vaccine last year, why not? _____
5. If you did NOT receive the Flu Vaccine last year, were you exempted? [ ] Yes [ ] No
6. Have you ever been PREVIOUSLY exempted from receiving the Flu Vaccine? [ ] Yes [ ] No
7. If previously exempted, what was the DATE of the exemption? _____
8. If previously exempted, where did you receive your Flu Medical Exemption? _____
9. Do you have an egg allergy and require an egg-free flu vaccine? [ ] Yes [ ] No

Please note that pregnancy is not considered a contraindication to the flu vaccine (https://www.acog.org/patient-resources/faqs/pregnancy/the-flu-vaccine-and-pregnancy).

Additional information: _____

AUTHORIZATION AND ACKNOWLEDGMENT

I authorize UM Employee Health Office to request and receive documentation and information regarding my application for medical exemption. This will be used for the purposes of considering a medical exemption from receiving influenza vaccination. The mandatory Influenza Vaccine Program is a condition of my employment as a health care worker at the University of Miami. I hereby certify that the information contained herein is accurate and true to the best of my knowledge. I understand that any misrepresentation or the provision of false information will result in disciplinary action up to and including termination of my employment with the University of Miami.

Employee Signature: _____**Date**:_____

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Healthcare Provider Form

Section 2 – To be completed by your Healthcare Provider (MD, NP, DO, or PA).

Attention Provider: Please complete below and provide the employee with or progress/visit notes that specifically indicate the contraindication/s for the patient receiving the Flu vaccine. The entire patient chart is not required. **Please note that a history of egg allergy alone will not be accepted as a reason for a medical exemption, as egg free flu vaccines will be available.** Additionally, **pregnancy is not considered a contraindication to the flu vaccine** (https://www.acog.org/patient-resources/faqs/pregnancy/the-flu-vaccine-and-pregnancy).

Patient Last Name_____ First Name_____ DOB:_____

1. Please explain the medical reason/s why this applicant is unable to receive the Influenza Vaccine below.
2. **Please provide the patient with copies of medical records indicating the contraindication/s for the Flu Vaccine. Copies of progress notes, visit notes, etc. demonstrating Flu Vaccine contraindication must accompany this application.**

Please describe the medical contraindication/s why this person should NOT receive the Flu Vaccine:

_____

_____

_____

By my signature below, I hereby certify that the information contained herein is accurate and true to the best of my knowledge.

_____ _____

Signature of Healthcare Provider ***(No signature stamp accepted).*** Date

PRINTED NAME OF HEALTHCARE PROVIDER: _____

PRACTICE NAME: _____OFFICE PHONE NUMBER: _____