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)

<table>
<thead>
<tr>
<th>Name: (Last)</th>
<th>(First)</th>
<th>C# or Workday#</th>
</tr>
</thead>
<tbody>
<tr>
<td>Email:</td>
<td></td>
<td>Personal Phone #</td>
</tr>
<tr>
<td>Department Name:</td>
<td>Job Title or Position:</td>
<td></td>
</tr>
<tr>
<td>Supervisor Name:</td>
<td>SUPERVISOR Phone #</td>
<td></td>
</tr>
<tr>
<td>Work Address:</td>
<td>Building Name:</td>
<td>Room#</td>
</tr>
</tbody>
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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](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: ____________

Influenza Vaccine Medical Exemption  Effective Date: 8/2016; updated 8/2020
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: _________________________