Influenza Vaccination Medical Exemption Request
for Employees

Please note that Employees should submit their application for Medical Exemption through Workday at http://workday.miami.edu

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 print the Healthcare Provider Form below and provide it to your healthcare provider. Please request medical records that support your request for a medical exemption at the time of your visit.
  2. Once you have the completed Healthcare Provider Form and have the medical records, please log into workday at http://workday.miami.edu.
  3. In Workday, please complete the application for a medical exemption and upload the completed Healthcare Provider Form with the relevant medical records.

Where can I complete my application?
The completed form and all required supporting documentation should be submitted at http://workday.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
Healthcare Provider Form

PLEASE PRINT THIS FORM – TO BE COMPLETED BY YOUR HEALTHCARE PROVIDER

Attention Provider: Please complete below and provide the employee with the relevant 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: ________________