MEDICAL EXEMPTION FROM COVID-19 VACCINATION

PART 1 – TO BE COMPLETED BY THE EMPLOYEE

Employee Name	**Date of Birth**	**Phone Number**
Employer Name		**Date of Request**
Please select yes if this exemption is on the basis of pregnancy or anticipated pregnancy. **YES ☐**		

PART 2 – TO BE COMPLETED BY THE EMPLOYEE'S MEDICAL PROVIDER

Employee's Name	
Physician, Physician Assistant, or Advanced Practice Registered Nurse It is my professional opinion as a physician or physician assistant who holds a valid, active license under chapter 458 or chapter 459, Florida Statutes, or an advanced practice registered nurse who holds a valid, active license under chapter 464, Florida Statutes, that COVID-19 vaccination is not in the best medical interest of the employee.	
Medical Provider Signature	**Date**
Medical Provider Name (print)	**Medical Provider License Number**

NOTE: Pursuant to section 381.00317(2), Florida Statutes, this completed exemption statement requires the employer to allow the employee to opt-out of the employer's COVID-19 vaccination mandate.