**Accredited Personnel Vaccination Program Declination Form** *(Revised August 26, 2021)*

## Section 1 – Vaccine Declination

*All personnel seeking an exemption from vaccination must complete this Section*

**By completing this Section 1, I am declaring that I am UNABLE TO BE VACCINATED FOR COVID-19 on the following basis (check all that apply):**

☐ **Medical/Disability Accommodation:** I have a medical condition or disability that prevents me from being able to take any COVID-19 vaccine. *NOTE*: To be eligible for this exemption, I understand that I must also provide to my employer a written statement signed by a **physician**, **nurse practitioner**, **or other licensed medical professional practicing under the license of a physician**, stating that I qualify for the exemption (but the written statement should not describe the underlying medical condition or disability) and indicating the probable duration of my inability to receive the vaccine (or if the duration is unknown or permanent, so indicate). **I will arrange for the completion of Page 2 of this form for that purpose.**

☐ **Religious Belief Accommodation:** I have a sincerely held religious belief, practice, or observance (whether connected to a traditionally recognized religion or held with the strength of traditional religious views) that prevents me from taking any of the FDA authorized or approved COVID-19 vaccines. My sincerely held religious belief, practice, or observance is described as follows:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

## Section 2 – Signature and Attestation

*All Personnel who complete any section of this form must complete this Section*

I declare, under penalty of perjury under the laws of the State of California, that the statement(s) in Section 1 above are true and correct.

Signature: ______________________________________________________________

Printed name: __________________________________ Date: ____________________

Location (City and State) where signed: ________________________________________

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## Page 2: MEDICAL/DISABILITY ACCOMMODATION

**To Healthcare provider:**

In order for a person who works, provides services, or volunteers in High Risk Settings, certain additional health care settings, and certain indoor businesses in Los Angeles County to qualify for a Medical/Disability Accommodation to the requirement to receive a COVID-19 vaccination, their healthcare provider (only a physician, nurse practitioner, or other licensed medical professional practicing under the license of a physician) must complete the following form to be provided by the person to their employer or other Business location where they work or volunteer.

*NOTE – Do not state that nature of the underlying medical condition or disability.*

Name of person seeking medical/disability exemption: ________________________________________

Date of birth of person seeking exemption: __________________________________________________

Anticipated duration of medical condition/disability (or indicate if unknown or permanent): __________
______________________________________________________________________________________

**By completing and signing this form, I certify that my client/patient listed above should not receive the COVID-19 vaccine and should be granted an exemption for medical reasons, per the most up-to-date guidelines from the Centers for Disease Control and Prevention (CDC), including:**

☐ Documented history of severe allergic reaction to one or more components of all of the COVID-19 vaccines available in the U.S.

☐ Documented history of severe or immediate-type hypersensitivity allergic reaction to a COVID-19 vaccine; person cannot be vaccinated with one of the other available formulations.

*Please check either box above (or both boxes) and explain the specific contraindication to vaccination here, but do **not** identify the underlying medical condition or disability – attach a separate sheet if necessary:*

______________________________________________________________________________________

______________________________________________________________________________________

**I certify the above information to be true and accurate, and I request exemption from the COVID-19 vaccination for the above-named individual.**

Name of physician, nurse practitioner, or other licensed medical professional practicing under the license of a physician: ____________________________________________________________

Signature: ____________________________________________________________

Dated: ____________________________________________________________

License Number: ____________________________ NPI: ____________________________

Address: ____________________________________ Phone: ____________________________

If practicing under the license of a physician, name and license number of physician:

________________________________________ ________________________________________