Note: This form is for use in California only.

HEALTHCARE WORKER COVID VACCINE DECLINATION FORM

Pursuant to an order from the California State Public Health Officer ("Order"), and subject only to limited exceptions set forth below, workers in Health Care Facilities must have their first dose of a one-dose regimen or their second dose of a two-dose regimen against COVID-19 by September 30, 2021.

Under the Order, vaccination is mandatory for continued eligibility to work unless a worker is exempted due to seeking a reasonable accommodation due to (1) Religious Beliefs or (2) Qualifying Medical Reasons. Any worker seeking an exemption from the vaccine mandate must complete and sign this form, and, where applicable, submit a signed Healthcare Provider Statement. Workers granted an exemption will be required to comply with the mandatory requirements for unvaccinated individuals as directed by the California Department of Public Health. Workers are considered out of compliance with the vaccination program if they fail to complete, sign, and submit all applicable forms, and will not be permitted to work.

Religious Exemption

If you wish to claim a religious exemption from mandatory vaccination, please sign the attestation below.

I have the following sincerely held religious belief, practice, or observance that prevents me from taking any of the COVID-19 vaccines authorized by the FDA:

_____

_____ _____

Signature Date

_____

Printed Name

_____

3-4 ID for employees of HCA Healthcare affiliates

Medical Exemption/Disability Accommodation

If you wish to claim a medical exemption from mandatory vaccination, please sign the attestation below.

I have a medical condition or disability that prevents me from taking any of the COVID-19 vaccines authorized by the FDA. To be eligible for this exemption, I understand that I must provide to my employer (or to the facility where I volunteer or otherwise work) a written statement signed by a physician, nurse practitioner, or other licensed medical professional practicing under the license of a physician, that I qualify for the exemption and indicating the probable duration of my inability to receive the vaccine (or indicating that the duration is unknown).

_____ _____

Signature Date

_____

Printed Name

_____

3-4 ID for employees of HCA Healthcare affiliates

(See next page for Healthcare Provider Statement)

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HEALTHCARE PROVIDER STATEMENT
SUPPORTING DECLINATION OF MANDATORY COIVD-19 VACCINATION

I am a:

_____ Physician

_____ Nurse Practitioner

_____ Other licensed medical professional practicing under the license of a physician

Explain: _____

By completing and signing this form, I certify that my patient identified below has a medical condition or disability that prevents them from being able to receive any FDA-authorized vaccine for COVID-19. *NOTE – Do not state the nature of the underlying medical condition or disability.*

_____
Signature

_____
Printed name

_____
License number

_____
Physical address (No P.O. Box) and telephone number

Patient Information

_____ _____
Patient name Patient date of birth

_____
Anticipated duration of medical condition or disability
(or state if duration unknown)