https://depts.washington.edu/uwmmktg/wp-content/uploads/2012/06/UWMedicineLogoBlack.jpg

**Dear Provider,**

The goal of UW Medicine is to vaccinate 100% of our employees against COVID -19. We provide free COVID-19 immunizations to all current employees and staff. However, currently available COVID-19 vaccinations may not be appropriate for a small number of employees (e.g. individuals with a history of severe reaction to a previous vaccine component). Guidance for medical exemptions for COVID-19 vaccination can be viewed here: (<https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html> ). ***Forms completed by the employment candidate will NOT be accepted.***

Please note that the following are **NOT** considered contraindications to COVID-19 vaccination:

* Local injection site reactions after previous COVID-19 vaccines (erythema, induration, pruritus, pain)
* Expected systemic vaccine side effects in previous COVID- 19 vaccines (fever, chills, fatigue, headache, lymphadenopathy, vomiting, diarrhea, myalgia, arthralgia)
* Vasovagal reaction after receiving a dose of any vaccination
* Being an immunocompromised individual or receiving immunosuppressive medications
* Autoimmune conditions, including Guillain-Barre Syndrome
* Allergic reactions to anything not contained in the COVID-19 vaccines, including injectable therapies, food, pets, venom, environmental allergens, oral medication, latex, etc
* Pregnancy or breastfeeding
* Immunosuppressed person in the employee’s household
* Alpha-gal Syndrome
* Allergy to egg or gelatin
* Having a positive antibody titer

Please complete the following form and return it to your patient, who should submit the completed form to their recruiter.

**Patient Name (print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Candidate ID \_\_\_\_\_\_\_\_\_\_\_\_**

**A licensed healthcare provider in the State of Washington must complete and sign this section (e.g. MD, DO, ND, PA, ARNP). Please select the medical contraindication to vaccination below:**

|  |
| --- |
| □ Severe allergic reaction (e.g. anaphylaxis) after a previous dose or to a component of a COVID- 19 vaccine. Please describe response in detail below and contraindication to alternatives.  □ Immediate allergic reaction to a previous dose or known (diagnosed) allergy to a component of the vaccine. Please describe response in detail below and contraindication to alternative vaccines.  □ Other medical circumstance preventing vaccination with any available COVID-19 vaccine. Be specific and describe in detail below: |
|  |

Provider signature Print name

WA State Medical Provider Number

Medical Facility: Date