



COUNTY OF LOS ANGELES

HEALTHCARE PROVIDER STATEMENT For Exemption from SARS-CoV-2 (COVID-19) Vaccination Policy

INSTRUCTIONS TO THE HEALTHCARE PROVIDER:

The County of Los Angeles (County) is requiring that all County employees be vaccinated against COVID-19.

Your patient has requested, as a reasonable accommodation, to be exempted from the County's COVID-19 vaccination policy for medical reasons.

Please complete this form to assist the County in evaluating your patient's request.

Please note that as part of this process, we are ONLY seeking confirmation of your patient's medical inability to be vaccinated, and the duration of such, if applicable.

Do not provide any information identifying your patient's medical condition, diagnosis, or treatment. We are not requesting, nor can we receive, such information.

The authorities that allow us to request and receive the information being requested in the attached questionnaire are the two following California laws:

- **California Confidentiality of Medical Information Act** (California Civil Code Section 56.10.8(b)): The County can receive information from a Health Care Provider that:
 - "(B) Describes functional limitations of the patient that may entitle the patient to leave from work for medical reasons or limit the patient's fitness to perform his or her present employment, provided that no statement of medical cause is included in the information disclosed."
- **California Code of Regulations** (CCR) (tit 2 § 11069(d)) provides that:
 - "The applicant or employee shall cooperate in good faith with the employer..., including providing reasonable medical documentation where the disability or the need for accommodation is not obvious and is requested by the employer..."

IMPORTANT

Do not identify the patient's diagnosis, disability, or other medical information (other than COVID-19 diagnosis in Part B) as this document will be returned to the County.



HEALTHCARE PROVIDER STATEMENT

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SECTION A: To be completed by Employee

EMPLOYEE NAME	EMPLOYEE ID
JOB TITLE	DEPARTMENT

SECTION B: To be completed by the Healthcare Provider

I have reviewed the **Instructions to this Healthcare Provider Statement** for the above-named patient and can provide the following certification:

(Check boxes and insert text as appropriate)

1. Is your patient medically restricted from receiving the COVID-19 vaccine?

NO, my patient is not medically restricted from receiving the COVID-19 vaccine.
(Please skip to the end of this questionnaire and sign and date.)

YES, my patient is medically restricted from receiving the COVID-19 vaccine.
Please explain:

a. What is the duration of the restriction from receiving a COVID-19 vaccine?

PERMANENT, it is not medically expected that my patient will ever be able to receive a COVID-19 vaccine.

TEMPORARY, it is anticipated that my patient will be cleared to receive a COVID-19 vaccine on or about _____ (date).

UNKNOWN. I am unable to comment on my patient's ability to receive a COVID-19 vaccine in the future.

HEALTH CARE PROVIDER NAME	HEALTH CARE PROVIDER PHONE/EMAIL
LICENSE TYPE, # AND ISSUING STATE	PHYSICIAN SUPERVISOR NAME AND LICENSE # FOR A PHYSICIAN ASSISTANT WORKING UNDER A PHYSICIAN'S LICENSE)
HEALTHCARE PROVIDER SIGNATURE & DATE	

FOR DEPARTMENT USE ONLY: FORM RECEIVED ON _____, BY _____