**HEALTHCARE PROVIDER STATEMENT**
**FOR EXEMPTION FROM SARS-CoV-2 (COVID-19) VACCINATION MANDATE**
**FOR EMPLOYEES SUBJECT TO (CMS) OMNIBUS COVID-19 HEALTH CARE STAFF VACCINATION INTERIM FINAL RULE**

**INSTRUCTIONS TO THE HEALTHCARE PROVIDER:**

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

**Your patient, who is an employee with a County healthcare organization, has requested, as a reasonable accommodation, to be exempted from the County's COVID-19 vaccination mandate for medical reasons.**

Please complete this form to assist the County in evaluating your patient's request. This form may only be completed by a licensed medical doctor (MD), a certified physician's assistant (PA-C), a registered nurse practitioner (RNP), or Doctor of Osteopathy (DO).

**Do not provide any information identifying your patient's medical condition, diagnosis, or treatment other than what is required by the attached Centers for Medicare and Medicaid Services (CMS) Regulations. 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 following laws and regulations:

- **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) (Title 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…"

- **Centers for Medicare & Medicaid Services (CMS) Omnibus COVID-19 Health Care Staff Vaccination Interim Final Rule** (42 CFR Parts 416, 418, 441, 460, 482, 483, 484, 485, 486, 491 and 494)
  – provides that for staff working for Medicare and Medicaid-certified provider and supplier types who request a medical exemption from COVID-19 vaccination, all documentation submitted must confirm "which of the authorized or licensed COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications. "

***IMPORTANT***

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

# HEALTHCARE PROVIDER STATEMENT FOR EXEMPTION FROM SARS-CoV-2 (COVID-19) VACCINATION MANDATE FOR EMPLOYEES SUBJECT TO (CMS) OMNIBUS COVID-19 HEALTH CARE STAFF VACCINATION INTERIM FINAL RULE



## SECTION A: To be completed by Employee

| EMPLOYEE NAME | EMPLOYEE ID |
|---|---|
| JOB TITLE | DEPARTMENT |

## SECTION B: To be completed by the Licensed Healthcare Provider

I acknowledge that my patient is employed by the County of Los Angeles in a job that is subject to the regulations established by the federal CMS. I have reviewed the **Instructions to this Healthcare Provider Statement** for the above-named patient and can provide the following certification:

**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 following vaccine(s), and I recommend that they be exempted from the COVID-19 vaccination requirement (Please check the box for each vaccine for which your patient has a recognized clinical contraindication):

☐ Pfizer-BioTech COVID-19 vaccine
☐ Moderna COVID-19 vaccine
☐ Janssen (Johnson & Johnson) COVID-19 vaccine
☐ WHO-approved COVID-19 vaccine: _____

**2. The CMS Omnibus COVID-19 Health Care Staff Vaccination Interim Final Rule provides for temporary delays in vaccination, as recommended by the CDC[1], due to clinical precautions and considerations.**

**a. What is the <u>duration of the restriction</u> 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.

[1] https://www.cdc.gov/vaccines/covid-19/downloads/summary-interim-clinical-considerations.pdf

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| EMPLOYEE NAME | EMPLOYEE ID |
|---|---|
| JOB TITLE | DEPARTMENT |

**b. List the recognized clinical reason(s) for the contraindication.**

☐ Anaphylaxis to prior Moderna/Pfizer vaccine

☐ Anaphylaxis, blood clot, or Guillain-Barre related to prior J&J/Janssen vaccine

☐ Anaphylaxis to Polyethelene glycol – Avoids in all medications and all foods containing these products.

☐ Anaphylaxis to Polysorbate – Avoids in all medications and all foods containing these products.

**I certify that I am acting within my respective scope of practice as defined by, and in accordance with, all applicable State and local laws.**

| 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 ERT TEAM USE ONLY: FORM RECEIVED ON _____, BY _____