**Jewish Community Center of Greater Pittsburgh**

**\*MEMBER Request for Medical Exemption from Vaccination**

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **(Print Last, First, MI) (mm/dd/yyyy)**

**Email Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Instructions for Submission of Vaccination Exemption Request**

Please complete this request and submit the completed form to hr@jccpgh.org. While the JCC will carefully review all requests for medical exemptions, approval is not guaranteed. After your request has been reviewed and processed, you will be notified, in writing, if an exemption has been granted or denied. The decision is final and not subject to appeal. Individuals are permitted to reapply if new documentation and information should become available.

Medical exemptions must be requested annually. If approved, the exemption will remain in effect for the duration of the JCC fiscal year which concludes on August 31st. Individuals with approved exemptions may request to recertify exemptions each year.

**Member Section and Attestation:**

By submitting this application, I am requesting a medical exemption from vaccination for the following immunization required by the Jewish Community Center of Greater Pittsburgh (JCC):

**COVID-19 \_\_\_\_\_\_\_ (please initial)**

**As evidenced by my signature below, I acknowledge and agree to the following in the event that my exemption requested is granted:**

* I have reviewed the information on the risks associated with Covid found on the JCC Website ([Jccpgh.org](https://jccpgh.org/app/uploads/2021/08/general-covid-info-1.pdf)).
* I have been informed that I may be placing myself and others at risk of serious illness should I contract a disease that could have been prevented through proper vaccination.
* I understand that an individual who has been exempt from a vaccination is still considered susceptible to the disease(s) for which the vaccine offers protection.
* I understand that, for the safety of the JCC community, I will be required to comply with the JCC’s infection control measures.
* I understand that, if I am applying for a medical exemption from COVID-19 vaccination, I must comply with the JCC’s COVID-19 mitigation protocols.
* I will wear a mask in all indoor spaces at all times.
* I will respect physical distancing guidelines when in the presence of others.
* I will comply with any additional obligations as may be required by the JCC or other public health mandates.
* I understand that failure to follow these requirements may result in suspension of my membership benefits from the Jewish Community Center of Greater Pittsburgh.

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**Member Signature Date**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Parent/Legal Guardian (if under age 18) Date**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Printed Name of Parent/Legal Guardian (if under age 18)**

***\* MEMBER*** *includes both members of the JCC and others who use JCC facilities and/or programs*

**Healthcare Provider Section and Verification:**

A licensed physician, physician’s assistant, or nurse practitioner must complete the medical exemption statement and provide their information below. Forms completed by the employee will not be accepted.

**Healthcare Provider Instructions:** Completing this form verifies that the following medical contraindication precludes vaccination for the below-selected vaccine(s). Guidance for medical exemptions for these vaccinations can be obtained from the most recent recommendation of the Advisory Committee on Immunization Practices (ACIP) available in the Center for Disease Control and Prevention publication, Morbidity and Mortality Weekly Report.

**Name of Member (Printed):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Check Applicable Vaccine(s):** **□** COVID-19

**Provide a detailed explanation of the specific medical contraindication requiring a vaccine exemption:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This medical contraindication is: □ Permanent **□** Temporary

If temporary, please provide length of time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***I hereby certify that the above-named patient qualifies for a medical exemption from the above-referenced vaccine(s) and that the medical contraindication is well-documented in their health record.***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Healthcare Provider Date**

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**Printed Name**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone Email**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Practice Address**

**FOR OFFICE USE ONLY:**

**APPROVED:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DECLINED:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_