LCMC Health

REQUEST FOR MEDICAL ACCOMMODATION: COVID-19 EXEMPTION OR DEFERRAL

Instructions for completion by employees or, as applicable, students, residents, other learners, or other third parties (all collectively referenced in these forms as "Covered Individuals"):

Step 1: Complete Section 1 of the *Request for Medical Accommodation: COVID-19 Exemption or Deferral* form. The portion of Section 1 regarding consent to release medical information is not required but will often expedite any necessary follow up communications or clarifications needed from the Covered Individual's healthcare provider. Sign and date Section 1 of the form in the spaces indicated.

Step 2: Take the form to the appropriate health care provider and ask him/her to complete Section 2, *Interactive Process – Medical Questionnaire*.

Step 3: Submit the completed forms through the Employee Health Department by the date established in the LCMC Health Vaccine Policy.

Step 4: You will be contacted with a decision regarding your deferral/exemption request or for additional information if needed to reach a decision.

LCMC Health

REQUEST FOR MEDICAL ACCOMMODATION: COVID-19 EXEMPTION OR DEFERRAL

Section I: For Completion by the Covered Individual

Please complete Section I of this form and submit it through the Employee Health Department by the deadline established in the LCMC Health Covid-19 Vaccine Policy.

Printed Name: _____ **Employee or Student Number:** _____

Job Title: _____

Preferred Phone No.: _____

Email: _____
[Note that all written communications concerning this Request will be sent via this email address only]

Employed/Home Facility: [Check Applicable Facility]

- ☐ Children's Hospital
- ☐ Children's Hospital Medical Practice Corporation
- ☐ East Jefferson General Hospital
- ☐ East Jefferson Physicians Group, LLC
- ☐ East Jefferson Radiation Oncology, LLC
- ☐ Metairie Physician Services, Inc.
- ☐ West Jefferson Medical Center
- ☐ New Orleans Physicians Services, Inc.
- ☐ Touro Infirmary
- ☐ Crescent City Physicians, Inc.
- ☐ University Medical Center
- ☐ New Orleans East Hospital
- ☐ NOLA Physician Group
- ☐ LCMC Health Corporate Office
- ☐ LCMC Health Anesthesia Corporation
- ☐ Other _____

If a student or other learner, please list school affiliation: _____

NOTICE TO COVERED INDIVIDUALS:

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. 29 C.F.R. 1635.8(b)(1)(B)

Covered Individual's Signature: _____ **Date:** _____

Section 1, Continued: Consent to Release of Medical Information

Covered Individual's Printed Name: _____

Employee or Student Number: _____

I understand that LCMC Health, or its affiliated entities (referred to collectively as "LCMC Health"), may need to obtain clarification, additional medical documentation, or to communicate verbally with my healthcare provider with regard to my request for exemption from or deferral of the requirement to obtain the COVID-19 vaccine.

I authorize LCMC Health to obtain medical information or clarification and otherwise to communicate verbally, as needed, with the physician/physician's office indicated in Section 2 of this form for the limited purposes stated above. I understand that I am not required to allow this direct communication but declining to do so may delay implementation of my request. I further understand that I may revoke this consent at any time in writing.

I have read and understand the nature of this consent and release.

_____ _____

Covered Individual's Signature Date

Section II: For Completion by the Health Care Provider

This section of the form must be completed by a medical provider.

INTERACTIVE PROCESS - MEDICAL QUESTIONNAIRE

Patient's Name: _____

Health Care Provider's Name: _____

Health Care Provider's Address: _____

Type of Practice/ Medical Specialty: _____

Healthcare Provider's NPI: _____

Telephone: (_____) _____ Fax: (_____) _____

[The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. 29 C.F.R. 1635.8(b)(1)(B)]

Instructions to the Health Care Provider: Your patient has requested an accommodation in the form of an exemption or deferral of the deadline to receive the COVID-19 vaccine. Please answer the following questions to assist LCMC Health to understand the basis for the requested exemption or deferral and to make a decision based upon the most recent relevant medical guidance.

1) Does your patient have a documented severe life-threatening allergic reaction (anaphylaxis requiring epinephrine) or immediate systemic allergic reaction (within four hours of receipt) to all of the FDA authorized COVID-19 vaccines or a component of each of them? (See https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html#Appendix -C)

☐ Yes ☐ No

If yes, please indicate the vaccine type or the component to which the allergy has been documents:

_____

If yes, please indicate the type of allergy experienced:

_____

_____

2) Does the patient have a reason to defer vaccination due to any of the following medical reasons:

a. Patient has undergone hematopoietic or solid organ transplant within the past 3-6 months.

☐ Yes ☐ No

If yes, date of transplant: _____

If yes, end date of requested deferral (must be within 3-6 months of transplant): _____

b. Patient has received COVID-specific monoclonal antibodies in the past 90 days (with provider documentation)

☐ Yes ☐ No

If yes, name of medication: _____

If yes, date of receipt of medication: _____

If yes, end date of requested exemption (must be within 90 days of receipt):

_____

3) Based on the most recent relevant medical guidance, the circumstances above describe the instances where receipt of the COVID-19 may be contraindicated. However, if you believe that the patient is otherwise incapable of receiving the vaccine for medical reasons, please provide the following information:

a. Nature of the condition which prohibits receipt of the COVID-19 vaccine.

_____

_____

b. Likely duration of the condition. _____

c. Basis for the clinical opinion that the vaccine is contraindicated due to the patient's medical condition. (Please be as descriptive as possible so that LCMC Health may fully evaluate whether a vaccine exemption or deferral is warranted given the current medical evidence, guidance, and expert opinion)

_____

_____

_____

_____

Signature of Health Care Provider: _____ Date:_____

For Internal Use Only:

Date Received: _____ Sent to Medical Review Committee: _____

Medical Review Committee Review Date: _____

Additional Information Requested on: _____ Received: _____

Denied ☐ Approved ☐

Communicated Response to Covered Individual On: _____

By: _____