**COVID-19 Vaccination Exemption Request**

Healthcare for the Homeless – Houston (HHH) will consider exemptions to the COVID-19 vaccination for certain verified medical or religious reasons. HHH volunteers who wish to receive an exemption from the COVID-19 vaccination for medical or religious reasons must complete this request form within 15 days of beginning to volunteer in any department or within 10 days following notice of the COVID-19 policy if already volunteering for HHH, submit it for review and receive approval within 5 days of submitting the form.

Medical exemptions are allowed if a volunteer is unable to receive a COVID-19 vaccine due to their own disability or medical condition. Completed exemption request forms must be signed by the volunteer’s licensed Provider (i.e.: MD, DO, NP, PA). Religious exemptions are allowed for individuals who are unable to receive the COVID-19 vaccine due to their sincerely held religious beliefs, practices or observances. HHH will review these exemptions as needed, and staff members will be asked to recertify if/when needed, and at least once every year.

Exemption requests will be reviewed by the Chief Executive Officer and/or the Chief Medical Officer/Medical Director and individuals will be notified of the outcome via email. Please refer to SECTION 300.14 COVID-19 Vaccination Policy in the HHH Personnel Policy manual for further information.

Requester’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last 4 digits of Social Security Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I am requesting a (check one): \_\_\_\_ Religious exemption \_\_\_\_ Medical exemption

**Medical Exemption (for Healthcare Provider’s Completion)**

I have evaluated this individual and attest that they are unable to receive the COVID-19 vaccine due to their personal disability or medical condition.

Healthcare Professional Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Location of Practice (Name/Address)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Religious Exemption**

I attest that I am unable to receive the COVID-19 vaccine due to my sincerely held religious beliefs, practices or observances.

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Requestor Signature Date