

Safety is a core value of Hartford HealthCare (HHC). To protect the safety of our patients, colleagues, and community, Hartford HealthCare requires all employed and non-employed colleagues to receive a flu shot by November 16, 2020 at 5PM.

If you believe that you have a medical reason that prevents you from receiving the influenza vaccine, you must submit this completed form by October 1 of the year in which you wish to be excused from receiving the vaccine. The exemption form will be reviewed by a team of healthcare professionals. HHC reserves the right to confirm the information provided with your healthcare provider. By signing this form, you hereby authorize HHC health professionals to contact your medical provider regarding conditions that prevent you from receiving the influenza vaccination. If your request is approved, you will be medically exempted from receiving influenza vaccine and you will be required to wear a mask while at any HHC location when you are within 6 feet of a patient/client during influenza season. If your request is not approved, you will be required to receive the influenza vaccine as a condition of your continued employment.

Colleague Signature \_\_\_\_\_ Date \_\_\_\_\_

### WHAT PAPERWORK DO I NEED?

**This Influenza Vaccination Medical Exemption Request form.**

- You, the colleague, should complete Section 1, and take the form to your healthcare provider (MD, NP, or PA).
- Your healthcare provider should complete Section 2, and provide you with **supporting documentation at the time of your visit.**

**Supporting documentation:**

- a. The medical documentation demonstrating a history of Guillain-Barre Syndrome (GBS) within 6 weeks of a previous dose of influenza vaccine (IIV or LAIV), severe, life threatening allergy to previous flu vaccine or vaccine components, or other medical condition that would prevent you from safely receiving a vaccine.
- b. Medical record/s with documentation must be provided along with your application form. Please retrieve copies of your medical record (progress notes, visit notes, ED notes) to support the information on your application form. Attach documentation (progress notes, visit notes, ED notes) to this application.
- c. **Please note that History of egg allergy alone will not be accepted as a reason for a medical exemption, as egg free flu vaccines are available. Please contact local OHS/EH with questions.**
- d. **Please note that HHC flu vaccines do not contain mercury.**
- e. Pregnancy absent other factors is an indication, not a contraindication to influenza vaccination.
- f. HHC does not utilize live influenza vaccination for staff. With this in mind being immunocompromised absent other factors is an indication, not a contraindication to influenza vaccination.

### WHERE DO I SEND MY APPLICATION?

**The completed forms and all required supporting documentation must be emailed to:**

Email: [FluGuru@hhchealth.org](mailto:FluGuru@hhchealth.org)

***\*Please note: Page 1 and Page 2 must be submitted***

### MY APPLICATION WAS DENIED. HOW CAN I APPEAL?

- A colleague who is denied a request for a medical exemption can appeal in writing **within three (3) business days of written denial notification.**
- The letter of appeal should be submitted to [FluGuru@hhchealth.org](mailto:FluGuru@hhchealth.org).

### WHO DO I CONTACT FOR MORE INFORMATION?

Questions regarding MEDICAL exemptions should be emailed to [FluGuru@hhchealth.org](mailto:FluGuru@hhchealth.org).

SECTION 1: **Colleague completes this section:**

Name: (Last)	(First)
Employee ID:	Department:
Date of Birth:	Division of HHC:
Employee's Street Address:	
Email:	Phone Number:

SECTION 2: **Medical Provider completes this section**

**Step 1:** Select the reason for exemption

- Severe (life threatening) allergy to a prior dose of a seasonal influenza vaccine **OR**
- Severe allergy to a component of the currently available season influenza vaccine **OR**
- Guillain-Barre Syndrome (GBS) within 6 weeks of a previous dose of influenza vaccine (IIV or LAIV) **OR**
- Other – Please provide this information in a separate narrative that describes the exception in detail (these requests will be reviewed on an individualized basis)

**Step 2:** Complete the following or provide office notes supporting the request.

Date/time of vaccination: \_\_\_\_\_ vaccine manufacturer/lot #: \_\_\_\_\_

Describe the patient's symptoms and the treatment provided:

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**Step 3:** Complete the following

Print Provider's Name: (Last)	(First)
Provider's Street Address:	City/State/Zip Code:
Phone Number:	Fax Number:

# Attention Provider and Colleague

## ATTACH MEDICAL RECORDS

Please attach medical records or progress/visit notes that specifically indicate the contraindication/s for the patient receiving the Flu vaccine. **Please note that the entire patient chart is not required** - only the *progress/visit note* of the healthcare provider ***demonstrating contraindications to the Flu Vaccine is required.***