COVID-19 Vaccine Medical Exemption Form

All Sinai Health employees and physicians are strongly encouraged to be vaccinated against COVID-19 and to report their vaccination status to Occupational Health & Safety (OHS). Reporting your vaccination status will ensure that our records are accurate in the event of an exposure or outbreak. If you have a medical contraindication preventing you from receiving the COVID-19 vaccine, it is recommended to have your treating physician/primary care provider complete the form below to confirm your medical exemption from vaccination. Please return the completed form to:

Mount Sinai Hospital	Email: gottheshot@sinaihealth.ca or Fax: 416-361-2663
Bridgepoint Active Healthcare	Email: gottheshot@sinaihealth.ca or Fax: 416-470-6725

Employee Information & Consent

Last Name: _____ First Name: _____

Job Title: _____ Department: _____ Phone Number: _____

I hereby authorize my physician/primary care provider to release the information on this form to OHS at Sinai Health for the purpose of updating my immunization records. I understand that I may revoke this authorization at any time.

Signature: _____ Date (dd/mm/yy):_____

Treating Physician / Primary Care Provider (PCP) Attestation

My patient has the following contraindication to receiving the COVID-19 vaccine as outlined by the National Advisory Committee on Immunization (NACI) **(check all that apply):**

- ☐ Severe allergic reaction or anaphylaxis after a previous dose of an mRNA vaccine.
- ☐ Severe allergic reaction to anaphylaxis to any of the components (including polyethylene glycol [PEG], tromethamine, and polysorbates) of the vaccine.

Please confirm which compound of the COVID-19 vaccine your patient has an allergy to (if known):

_____

More information about COVID-19 vaccine contraindications can be found at: https://www.canada.ca/en/public-health/services/immunization/national-advisory-committee-on-immunization-naci.html

As the Treating Physician / Primary Care Provider **(check all that apply):**

- ☐ I have reviewed the medical contraindications as outlined by the NACI.
- ☐ I have reviewed my patient's file.
- ☐ I confirm that the documentation on file is consistent with the selected contraindication above.
- ☐ I certify that my patient has the selected contraindications above.
- ☐ I support the request for a medical exemption from the COVID-19 vaccine requirements at Sinai Health.

Physician/PCP:_____
Print Name

Signature: _____ Date: _____

Regulatory College No. / Phone / Address

PHYSICIAN / PCP CLINIC STAMP

Sinai Health is committed to protecting your privacy. The personal information collected on this form is collected in accordance with the Occupational Health and Safety Act. It will be used and maintained by Sinai Health for the intended purpose of providing Occupational Health services. If you have any questions regarding the collection, use, and disclosure of the personal information provided on this form, please call us directly at 416-586-4800 x 7425 or e-mail us at covidvaccine@sinaihealth.ca.