Region of Waterloo

STATEMENT OF MEDICAL EXEMPTION – COVID 19 VACCINATION

SECTION A – FOR COMPLETION BY EMPLOYEE:

Full Name: _____ Date of Birth: _____

☐ New Job Candidate ☐ Volunteer ☐ Student ☐ Other:_____

Department/Division:_____ Contact Phone Number: _____

I, _____ hereby authorize my Healthcare Provider to supply the following information to the Disability Management team in the Human Resources and Citizen Services Department of the Regional Municipality of Waterloo (The Region) and if required, to discuss this information with my physician.

I understand that the information collected on this form will be used only for the purposes of determining my request for medical exemption under the Region's Mandatory COVID-19 Vaccination Policy.

I agree that a photocopy of this authorization be considered as valid as the original.

SIGNATURE: _____ **DATE:** _____

SECTION B: DECLARATION OF PHYSICIAN OR NURSE PRACTITIONER

I, _____ certify that, for medical reasons the above named individual is unable to receive a COVID-19 immunization with the current COVID-19 vaccines available in Ontario. I have also reviewed the **Medical Exemptions to COVID-19 Vaccination** guidance prior to certifying this medical exemption to ensure all criteria are met.

Select the Condition and/or Adverse Event Following Immunization

1. Pre-existing Condition(s)

- ☐ Severe allergic reaction or anaphylaxis to a component of a COVID-19 vaccine
- ☐ Myocarditis prior to initiating a mRNA COVID-19 vaccine series

2. Contraindications to Initiating a AstraZeneca/ COVISHIELD COVID-19 Vaccine Series

- ☐ History of capillary leak syndrome (CLS)
- ☐ History of cerebral venous sinus thrombosis (CVST) with thrombocytopenia
- ☐ History of heparin-induced thrombocytopenia (HIT)
- ☐ History of major venous and/or arterial thrombosis with thrombocytopenia following any vaccine

3. Adverse Events Following COVID-19 Immunization

- ☐ Severe allergic reaction or anaphylaxis following a COVID-19 vaccine
- ☐ Thrombosis with thrombocytopenia syndrome (TTS)/Vaccine-Induced Immune
- ☐ Thrombotic Thrombocytopenia (VITT) following the Astra Zeneca/COVISHIELD COVID-19 vaccine
- ☐ Myocarditis or Pericarditis following a mRNA COVID-19 vaccine
- ☐ Serious adverse event following immunization (e.g. results in hospitalization, persistent or significant disability/incapacity)

4. Other

☐ Actively receiving monoclonal antibody therapy OR convalescent plasma therapy for the treatment or prevention of COVID-19

Length of Exemption

☐ Permanent

☐ Temporary From _____ (date) to _____ (date)

Physician Name: _____ Designation: _____

Work Address: _____

Phone Number: _____

Signature:_____ Date: _____

Please return in confidence to:
Nora Power, R.N., C.O.H.N. (C.), Disability Management Advisor
Region of Waterloo
Human Resources and Citizen Services
TEL: 1-519-575-4522 FAX: 1-519-575-4454
To expedite processing of forms, documents can be e-mailed to npower@regionofwatereloo.ca