CITY OF LOS ANGELES

REQUEST FOR HEALTHCARE PROVIDER STATEMENT

For Exemption/Deferment to SARS-CoV-2 (COVID-19) Vaccination Requirement

CERTIFICATION REQUESTED FOR:

Employee Name	Employee ID
Job Title	Department

NOTIFICATION TO THE CERTIFYING MEDICAL PROFESSIONAL

The City of Los Angeles requires its employees be vaccinated against COVID-19 infection as a condition of employment. The City may grant exemptions or deferment to this requirement based on the following:

a) Medical exemption due to a contraindication or precaution to COVID-19 vaccination recognized by the U.S. Centers for Disease Control and Prevention (CDC) or by the vaccines' manufacturers based on the employee/individual's disability or medical condition; or

b) Medical deferment due to COVID-19 monoclonal antibody or convalescent treatment within the last 90 days; or

c) Medical deferment due to a positive COVID-19 test and present isolation period.

The individual named above is a patient under your care, who seeks a medical accommodation exempting or deferring them from the City of Los Angeles's employee Covid-19 Vaccination Requirement for one of the above reasons.

INSTRUCTIONS THE HEALTHCARE PROVIDER

Please complete the threshold questions by checking "yes" or "no" based on your personal knowledge and medical opinion.

Please complete **Section A** of this form by checking off all applicable boxes within this section ***if*** one or more of the contraindications or precautions to the COVID-19 vaccinations recognized by the CDC or the vaccines' manufacturers apply to the patient/employee identified above, based on their disability or medical condition.

Please complete **Section B** of this form by checking off all applicable boxes within this section ***if*** the patient/employee identified above has received a monoclonal antibody or convalescent treatment for COVID-19 within the last 90 days.

Please complete **Section C** of this form by checking off all applicable boxes within this section ***if*** the patient/employee identified above has received a positive COVID-19 test result and is in an isolation period at (or consistent with) your recommendation.

EMPLOYEE NAME	EMPLOYEE ID

IMPORTANT NOTE

***Do not* identify the patient's diagnosis, disability, or other medical information (other than a COVID-19 diagnosis in Part B) as this document will be returned to the City of Los Angeles.**

Please note the following from the Genetic Information Nondiscrimination Act of 2008 (GINA), which applies to all City of Los Angeles employees:

> *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.*

EMPLOYEE NAME	EMPLOYEE ID

HEALTHCARE PROVIDER STATEMENT

For Exemption to SARS-CoV-2 (COVID-19) Vaccination Requirement

TO BE COMPLETED BY THE CERTIFYING MEDICAL PROFESSIONAL

Please answer the following threshold questions (1 and 2):

1. Do you regard the individual requesting this certification as having a disability or medical condition that prevents your patient from receiving any of the available CDC recognized or FDA approved COVID-19 vaccinations?

   ☐ Yes
   ☐ No

2. Does the individual requesting this certification have a documented record of such disability or medical condition (meaning a historical background of having the disability or medical condition) that prevents your patient from receiving any of the available CDC recognized or FDA approved COVID-19 vaccinations?

   ☐ Yes
   ☐ No

If you answered “yes” to both questions 1 *and* 2, please complete the appropriate section (A, B, or C) on page 4:

EMPLOYEE NAME	EMPLOYEE ID

Section A: Contraindication to COVID-19 Vaccination

☐ I certify that one or more of the contraindications or precautions recognized by the CDC or by the vaccines' manufacturers for each of the currently available COVID-19 vaccines applies to the patient listed above, based on the patient's medical status or condition.

The contraindication(s) and/or precaution(s) is/are:

- ☐ Permanent
- ☐ Temporary; enter the expected end date:_____.

☐ I certify that in my professional opinion, the COVID-19 vaccination using ***any*** of the currently available COVID-19 vaccines is inadvisable for this patient.

Section B: COVID-19 Treatment Within the Last 90 Days

☐ I certify that this patient has received monoclonal antibody or convalescent treatment for COVID-19 on (date)_____.

☐ I certify that in my professional opinion, the COVID-19 vaccination using ***any*** of the currently available COVID-19 vaccines is inadvisable for this patient within 90 days of the date referenced herein.

Section C: Positive COVID-19 Test Within the Last 10 Days

☐ I certify that this patient has received a positive COVID-19 test on (date) _____ and is in isolation under (or consistent with) my recommendation.

☐ I certify that in my professional opinion, the COVID-19 vaccination using ***any*** of the currently available COVID-19 vaccines is inadvisable for this patient until this patient is no longer within my recommended isolation period.

EMPLOYEE NAME	EMPLOYEE ID

As a licensed physician, I hereby certify the existence of a disability or medical condition that prevents the patient/employee identified above from receiving a COVID-19 vaccination and the need for an accommodation for this patient.

Please note: the Medical Board of California (Board) has informed licensees and the public that a physician who grants a mask or other exemption without conducting an appropriate prior exam and without a finding of a legitimate medical reason supporting such an exemption within the standard of care may be subjecting their license to disciplinary action. (8/8/21)

(See, https://www.mbc.ca.gov/News/COVID19-Updates.aspx)

_____ _____
Signature Date

_____ _____
Print Name Printed Professional Title

_____ _____
Medical License Number and Issuing State

_____

_____ _____
Health Care Facility Name Health Care Facility Address

_____ _____
Physician Phone Number Physician Email Address

_____
Physician Fax Number