CITY OF BURBANK
COVID-19 EMPLOYEE VACCINATION POLICY
MEDICAL EXEMPTION REQUEST FORM

Name:	
Board, Commission, or Committee:	
Contact number and email:	
Date:	

By submitting this form, I acknowledge I am requesting a medical exemption from the City's COVID-19 Employee Vaccination Policy.

Do not provide any information that identifies any diagnosis, disability, or other protected health information. The City does not and cannot require your diagnosis to process an exemption request.

Please check the box that applies:

☐ I am requesting an exemption due to a contraindication recognized by the U.S. Centers for Disease Control and Prevention for all FDA-EUA authorized or FDA licensed COVID-19 vaccines. My request is supported by the attached Medical Certification Form from my health care provider.

☐ I am requesting an exemption due to a medical condition or disability. My request is supported by the attached Medical Certification Form from my health care provider.

I certify that the information I have provided is accurate and truthful.

I understand that I need to have my health care provider complete the attached Medical Certification Form and include it with this Medical Exemption Request Form.

_____

Board, Commission, or Committee Member signature Date

CITY OF BURBANK
COVID-19 EMPLOYEE VACCINATION POLICY
MEDICAL CERTIFICATION FORM

Instructions to member: Please have your health care provider complete the applicable portions of this form.

Member/patient information (to be completed by employee):

Name:	
Board, Commission, or Committee:	
Contact number and email:	
Date:	

Health care provider information (to be completed by health care provider):

Name:	
License Type, No., & Issuing State:	
Office Address:	
Office Phone No:	

Instructions to health care provider: The City of Burbank requires its Board, Commission, and Committee Members to be vaccinated against COVID-19 infection. Members may request exemptions due to a medical condition or disability. ***Do not provide any information that identifies any diagnosis, disability, or other protected health information.***

Please check the boxes below that apply for the patient listed at the top of this form:

☐ One or more of the contraindications recognized by the U.S. Centers for Disease Control and Prevention or by the vaccine's manufacturers for each of the FDA-EUA authorized or FDA licensed COVID-19 vaccines applies to the patient listed above. For that reason, COVID-19 vaccination is inadvisable for this patient in my professional opinion. The contraindication(s) is/are:

☐ Permanent ☐ Temporary The expected end date is:_____

OR

☐ The patient listed above has a medical condition or disability that makes COVID-19 vaccination inadvisable in my professional opinion. The medical condition or disability is:

☐ Permanent ☐ Temporary The expected end date is:_____

I certify that the person listed above is my patient and that the information I provided on this form is complete and accurate.

_____

Health care provider signature Date