Medical Certification for Vaccination Exemption

Employee Name: _____

Dear Medical Provider,

United Therapy Services requires vaccination against *COVID-19* as a condition of demonstrating compliance to the current CMS Conditions of Participation. The individual named above is seeking an exemption to this policy due to medical contraindications.

Please complete this form to assist United Therapy Services in the reasonable accommodation process.

The person named above should not receive the COVID 19 vaccine due to:
This exemption should be: ☐ Temporary, expiring on: __/__/____, or when _____. ☐ Permanent.

I certify the above information to be true and accurate, and request exemption from the [*insert disease name*] vaccination for the above-named individual.

Medical Provider Name (print):	
Medical Provide Signature:	Date:
Practice Name & Address:	Provider Phone: