**COVID-19 VACCINATION MEDICAL EXEMPTION FORM**

**SECTION A: EMPLOYEE INFORMATION (TO BE COMPLETED BY THE EMPLOYEE)**

|  |  |
| --- | --- |
| Name:  | Primary Phone:  |
| Address:  | City:  |
| Email:  | Postal Code:  |
| Department:  | Classification: |

**SECTION B: CONSENT (TO BE COMPLETED BY THE EMPLOYEE)**

**I authorize the physician/practitioner to disclose information to Occupational Health & Safety at Thunder Bay Regional Health Sciences Centre regarding my medical condition for the purposes of validating COVID-19 Immunization Exemption.**

**I understand that Occupational Health & Safety at Thunder Bay Regional Health Sciences Centre will keep my medical information confidential but for the purpose validating COVID-19 Immunization Exemption. I consent to allow Occupational Health & Safety to relay my exemption status to my employer. A photocopy of the original authorization is as valid as the original.**

|  |  |
| --- | --- |
|  Employee Signature : | Date:  |

**SECTION C: TO BE COMPLETED BY PHYSICIAN OR REGISTERED NURSE IN THE EXTENDED CLASS**

|  |  |
| --- | --- |
|  Above-named individual has a medical reason they cannot be vaccinated against COVID-19  | □ YES □ NO  |
| Detailed description of medical reason/condition: |
| Is this exemption temporary? | □ YES □ NO |
| If yes, indicate the date that the temporary exemption ends:  |

**By affixing my signature below, I certify that I am a qualified medical doctor or a qualified registered nurse in the extended class, and that I have personally assessed and treated the above patient/employee. It is my opinion that the information is true and accurate.**

|  |
| --- |
| Practitioner Name: *(Please Print)* |
| Address:  |
| Telephone:  | Fax:  |
|  Signature:  | Date:  |

**Return form by confidential fax, email or mail to Occupational Health & Safety:** Fax #: 807-684-5832 | Email: OHS@tbh.net Address: 980 Oliver Rd, Thunder Bay, Ontario P7B 6V4