

**Request for Medical Exemption from Influenza Vaccination**

The University of Michigan promotes workforce diversity and an inclusive workplace for all workforce members as part of its equal employment opportunity commitments.

Please print the following information:

Date of Request: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ UMID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ Phone/Pager: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Department: ­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ Supervisor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If you did not receive a Michigan Medicine Medical exemption from receiving the flu vaccine last year, please have your physician complete the form below and upload it in your Enterprise Health Portal.**

Dear Michigan Medicine Workforce Member:

To protect patients, faculty, staff, and trainees, Michigan Medicine requires annual influenza vaccination for all workforce members. **Medical exemptions from the influenza vaccination will be approved only for individuals with a history of Guillain-Barre syndrome or other neurologic complications within 6 weeks of receiving a previous influenza vaccination.**

If you believe that you have a documented medical condition to the influenza vaccine as indicated above, please have your physician complete the remainder of this form and return it to OHS for review. You will be required to wear an approved surgical mask whenever in a UMHS clinical area for the duration of the influenza season.
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Dear Physician:

Please complete the form below. If you have any questions, please contact UMHS Occupational Health Service at (734) 764-8021.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ should not be immunized for influenza for the following reasons (Please check all that apply):
 (name of patient)

□ History of Guillain-Barre syndrome within 6 weeks of receiving a previous influenza vaccination.
**Please provide and attach a detailed narrative summary that describes the event.**

□ Other neurologic complications within 6 weeks of receiving a previous influenza vaccination.
**Please provide and attach a detailed narrative summary that describes the event.**

I certify that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ has the above condition to influenza vaccination.

*(name of patient)*

Physician signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

  *(Note: Signature stamp not acceptable)*

Medical license number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **The form MUST be uploaded in your Enterprise Health Portal by November 1st to ensure review and determination by the December 1st deadline.**