UHN
Toronto General
Toronto Western
Princess Margaret
Toronto Rehab
Michener Institute

UHN HEALTH SERVICES

TeamUHN Health Services Clinics | Wellness | Disability Management | WSIB

COVID-19 Vaccine Medical Exemption Form

All UHN employees and physicians are required to be vaccinated against COVID-19 and to report their vaccination status to Health Services. Reporting your vaccination status will ensure that our records are accurate in the event of an exposure or outbreak. If you have a medical contraindication preventing you from receiving the COVID-19 vaccine, you are required to have your treating physician complete the form below. Exemption from UHN COVID-19 policy will not be considered valid until a review has been completed by UHN Health Services. Please return the completed form to your appropriate work site:

HS TGH	HS PMH
Email: OHSTGH@uhn.ca Fax: 416-340-3463	Email: OHSPMH@uhn.ca Fax: 416-946-2093

HS TWH	HS TRI
Email: OHSTWH@uhn.ca Fax: 416-603-5121	Email: OHSTRI@uhn.ca Fax: 416-597-3026

Employee Information & Consent

Last Name: _____ First Name: _____

Job Title: _____ Department: _____ Phone Number: _____ I,

_____ (print name) hereby authorize my physician to release the information on this form to the Health Services Department at UHN for the purpose of updated my immunization records. I understand that I may revoke this authorization at any time.

Signature: _____ Date (dd/mm/yy):_____

Treating Physician Attestation

I attest that based on my knowledge of my patient and the information available to me, the above patient is under my care and has a medical contraindication which prevents them from receiving a COVID-19 vaccine at this time.

The medical contraindication must meet the criteria below as per the National Advisory Committee on Immunization (NACI). Please check the appropriate box:

- ☐ Severe allergic reaction or anaphylaxis after a previous dose of an mRNA vaccine
- ☐ Severe allergic reaction to anaphylaxis or to any of the components (including polyethylene glycol [PEG], tromethamine, and polysorbates) of the vaccine

Please confirm the compound of the COVID-19 vaccine that your patient is allergic to, and the type of allergy that was experienced:

_____

_____

Please note: Information submitted may require reporting to the Medical Officer of Health for further investigation. Has this been reported? ___YES ___ NO

Physician:_____
Print Name

Signature: _____ Date: _____

CPSO No. / Phone / Address

PHYSICIAN/ CLINIC STAMP

UHN is committed to protecting your privacy. The personal information collected on this form is collected in accordance with the Occupational Health and Safety Act. It will be used and maintained by Health Services for the intended purpose of providing Occupational Health services. If you have any questions regarding the collection, use, and disclosure of the personal information provided on this form, please call us directly at 416-979-4441