GRADY EMPLOYED STAFF NEW HIRE PACKET

Grady

Date: _____________

Pre-Placement/Post Job Offer Medical History Questionnaire

Start Date	Job Title			☐Grady ☐Vendor/Agency (**name below**)		Recruiter	
Last Name	First Name	Middle Initial/Name		Date of Birth / /		Age	Gender
Social Security	Phone		Email				
Street Number	Street Name				Apt#		
City	State	Zip Code					

PART I

1. What medical conditions are you currently under treatment for or have you been treated for in the past 5 years?

   a. ________________________________ d. ______________________________

   b. ________________________________ e. ______________________________

   c. ________________________________ f.______________________________

2. Please list **<u>all</u>** medications you are taking or have taken in the past 60 days ☐None

   a. ________________________________ d. ______________________________

   b. ________________________________ e. ______________________________

   c. ________________________________ f. ______________________________

3. What allergies do you have? ☐None

   a. ________________________________ c ______________________________

   b. ________________________________ d. ______________________________

4. Tuberculosis History

   a. Exposed to someone with known or suspected TB? ☐No ☐Yes, When? ___________

   b. Lived >1 month in high risk TB area? ☐No ☐Yes, When? ___________

   c. Current or planned immunosuppression (HIV, organ transplant, chronic steroids or medication)? ☐No ☐Yes

   d. I am currently experiencing? ☐None ☐ Cough >2 weeks ☐ Coughing up blood ☐ Fever ☐ Night Sweats ☐Unexplained weight loss ☐Unusual weakness or fatigue

   e. Positive TB skin Test? ☐No ☐Yes, When? ___________

   f. Positive TB blood Test? ☐No ☐Yes, When? ___________

   g. Abnormal Chest X-ray? ☐No ☐Yes, When? ___________

   h. Has a physician offered you TB treatment? ☐No ☐Yes, completed ☐Yes, did not complete ☐Yes, I declined

   List any medication treatment and length of treatment ____

Name___________________________________ Date of Birth__________________

5. Tobacco Use
   ☐ Never ☐ Quit When? _______________
   ☐ Cigarettes ☐ Snuff ☐ Cigars ☐ Pipe ___months of use ____years of use

6. Select hobbies and pastime activities below: ☐pottery ☐ photography ☐weaving ☐glass making ☐fine arts painting
   ☐ Wood working ☐Metal Working ☐Jewelry making ☐Work with chemicals ☐Bird Keeping ☐Taxidermy ☐Magician
   Other: ______________________________________

PART II

	Please answer the following questions	Yes	No
1.	Physical limitations, handicaps or disabilities that would prevent you from performing the essential functions of your job?		
2.	Do you anticipate needing any accommodations to assist you in performing your job?		
3.	Currently undergoing psychotherapy or under the care of a physician for any psychiatric condition?		
4.	Had a job-related injury?		
5.	Have you lost time from work due to a major illness or injury?		
6.	Applied for Worker’s Compensation benefits for any work-related injury?		
7.	Been diagnosed with a communicable disease such as HIV or Hepatitis?		
8.	Are you pregnant at this time?		
9.	Anticipate any surgery or hospitalization or major medical treatment within the next 12 months?		
10.	Been hospitalized in the past 10 years?		
11.	Failed a drug test or been required to see a substance abuse professional (SAP)?		
12.	Had a VA disability rating or been discharged from the military for medical reasons?		

Please **number and explain all yes answers** from above and include dates of treatment.

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Grady

Name___________________________________ Date of Birth___________________

PART III

Have you **ever had or been treated** for any of the following medical conditions? For any "yes" answers from below, provide additional information at the bottom of the page. **Describe in space below each question.**

	Yes	No			Yes	No
1. Visual problems including glasses or contacts?				21. HIV or Acquired Immunodeficiency Disease?		
2. Ear or Hearing Problems?				22. Diabetes?		
3. Migraines or Headaches?				23. Mental Health Condition such as ADHD, Anxiety, Depression etc)		
4. Fainting or losing consciousness				24. Liver Problems including Hepatitis?		
5. Dizziness?				25. Nerve conditions?		
6. Head Injury in past 5 years?				26. Neck Injury?		
7. Seizures or Epilepsy?				27. Chest /Rib Injury?		
8. Memory loss or Dementia?				28. Shoulder Injury?		
9. Stroke, Mini Stroke (TIA), Paralysis, Weakness?				29. Elbow Injury? (Tennis Elbow)		
10. Tuberculosis?				30. Wrist/Hand/Finger Injury? (Carpal Tunnel)		
11. Asthma, COPD, Bronchitis, Sleep Apnea, Shortness of Breath or other lung problem?				31. Abdominal Injury, Ulcers or Hernia?		
12. Cancer or Tumor?				32. Back Injury?		
13. Blood Clots or Bleeding Disorder?				33. Pelvic Injury?		
14. Thyroid Disorder?				34. Hip Injury?		
15. High Blood Pressure?				35. Upper Leg Injury?		
16. Heart Disease (Angina, Murmur, Heart Attack, Chest Pains, Irregular Heart Beat)				36. Knee Injury?		
17. Pacemaker, stents, implantable device or other heart procedure?				37. Lower Leg Injury?		
18. Vascular or Circulatory Problems?				38. Ankle/Foot/Toe Injury?		
19. Skin Disorder or Rash?				39. Arthritis?		
20. Kidney Problems?				40. Missing limb?		

Please **number and explain all yes answers** from above.

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________________________________ ________________________________ ______________

Reviewing Provider Name and Title **Provider Signature** **Date**

Created: 1/21/2021
Updated: 8/16/2021

Name___________________________________ Date of Birth___________________

Height_____(ft)______(in) Weight________(lbs) Blood Pressure________/________ Pulse________

Snellen Vision: 20/_______

Please read carefully and sign

I have received a conditional offer of employment. I understand that all individuals receiving offers of employment are required to complete a medical history questionnaire. The purpose of the questionnaire is to determine (1) my ability to perform the essential functions of the job that I have been offered, (2) whether I require any accommodations to perform those essential job functions and (3) whether I can perform those essential job functions without presenting a threat to the health and safety of myself or others. All job offers are conditional upon completion of this questionnaire, further evaluation if deemed necessary, and the disposition of the Employee Health and Wellness Clinic provider.

I understand that this questionnaire and any other medically necessary evaluation or testing is for the limited purpose described above and is not intended to provide a comprehensive screening for all medical conditions. I agree to complete any necessary authorization forms to obtain information from any hospital, clinic or physician necessary to make the determinations above. I understand that my refusal to complete such authorization forms may be considered cause for withdrawal of the conditional offer or discharge from employment. I understand that this limited evaluation does not establish a doctor patient relationship and I have been encouraged to establish a doctor patient relationship with a primary care physician to address my healthcare needs.

I understand that the federal Genetic Information Nondiscrimination Act (GINA) prohibits employers from asking questions pertaining to genetic testing or family medical history. I have not disclosed any health condition or potential health condition based on genetic testing or family history.

I attest that, to the best of my knowledge all of the information I have provided on this questionnaire is accurate and complete. I further understand that Grady Health System reserves the right to verify all information on this form and that any statements found to be false will be considered sufficient cause for withdrawal of a job offer or discharge without prior warning, at any time during my employment or assignment at Grady Health System.

I also understand that the information in the questionnaire and collected during the medical examination will be kept strictly confidential in a separate employee health file, apart from my personnel file. The information will be available only for the purposes authorized by the Americans with Disabilities Act, including disclosure to my manager or supervisor on an as needed basis regarding necessary restrictions or accommodations.

____ __________________________________

Signature of candidate Date

Urine Drug Screen

Urine drug screening is required of all applicants for employment and (temporary) contract employees of Grady Health Systems. I understand that my potential employer has requested that I provide a urine specimen that will be tested for the presence of controlled substances and drugs of abuse. I agree to submit to a urine sample by medically qualified personnel. I understand that if I test positive for controlled substances or drugs of abuse, I may be denied employment, and if I have started work, my employment may be terminated. I also understand that I will be given a reasonable opportunity to speak with a Medical Review Officer (MRO) before a positive test is reported to my employer.

I understand that if the laboratory report indicates a “substituted urine specimen” or an “adulterated urine specimen” the test will be treated as a positive test. Possession of devices or containers that could be used to provide a substituted specimen will be considered a refusal to test. Refusal to test is grounds for discharge or rescinding of an offer of hire. I understand that I may be required to repeat my urine drug screen if the laboratory reports a “negative dilute urine.” Finally I understand that Grady Health System may also require me to have a repeat urine collection if my specimen “temperature is out of range,” my urine specimen appears to be altered, there is conduct or evidence of an attempt to substitute or adulterate my urine specimen, my urine specimen is extremely dilute or there is an “invalid result” without a medical explanation.

____ __________________________________

Signature of candidate Date

Employee Health and Wellness Center
80 Jesse Hill Jr. Drive, SE, Clinic GA021
Atlanta, GA 30303
404-616-4600

INITIAL ONBOARDING HEALTH REQUIREMENTS

(Grady employee, medical staff, faculty, resident, contractor, vendor, volunteer, student)

1. ☐ Respirator Medical Evaluation *(waived with proof of FIT testing within past 1 year)*

OSHA requires the use of respirators to protect workers on the job from occupational disease caused by breathing contaminated air. This evaluation must be performed by a physician or licensed health care professional (PLHCP). It evaluates the physiological burden associated with respirator use. This evaluation is used to determine if it is medically safe for a worker to wear a respirator.

Required for Physician, NP, PA, anesthetist, nurse, care coordinator, chaplain, dentist, dental assistant, food service, housekeeping, interpreter, laundry, maintenance and engineering, nursing assistant, medical assistant, nutritionist, ordering organizer, clinical pharmacist, PT/OT /RT, speech therapist, security, safety, social worker, resource center associate, technicians, transporters, any role not mentioned above that provides-patient facing services or involves entering patient rooms

What does a Respirator Medical Evaluation involve?
- A review of the OSHA Respirator Medical Evaluation Questionnaire (**mandatory**)
- A limited physical exam in addition to any other testing may be required based on the job, workplace condition and health status

How should I prepare for the evaluation?
- Obtain the OSHA Medical Evaluation Questionnaire from Employee Health and Wellness Clinic or GradyNet

How often is a Respirator Medical Evaluation required?
- Initially
- When there are signs or symptoms that are related to the ability to wear a respirator
- When a physician or licensed health care professional (PLHCP) requires testing
- When the work conditions change

2. ☐ Respirator FIT Testing or ☐ Proof of FIT testing with a NIOSH approved respirator (*within past 1 year)*

Tight-fitting respirators, must form a tight seal with your face or neck to work properly. If your respirator doesn't fit your face properly, contaminated air can leak into your respirator face-piece. A FIT test is performed to test the seal between the respirator face-piece and the face of the worker.

What must occur before the test can be performed?
- A **respirator medical evaluation** must be performed by a physician or licensed health care professional (see above)

What type of testing do we offer and what does it involve?
- Qualitative testing**.** This is a pass/fail test, uses the sense of taste or smell or reaction to an irritant to detect leakage, while performing a series of maneuvers

How should you prepare for the respirator FIT?
- Shave any beard, mustache or side burns that will affect the seal of the respirator
  *****You are responsible for maintaining facial hair that will not interfere with mask seal, at all times**

How often must a FIT test be performed?
- At least annually
- If a different respirator face-piece other than the one originally used for fit testing will be used and with changes in physical condition that could affect respirator fit.

Created: 2/15/2021
Updated: 8/10/2021, 8/18/2021, 10/19/2021; 12/15/2021; 3/22/2022, 11/7/2022, 4/2023, 6/2023

Employee Health and Wellness Center
80 Jesse Hill Jr. Drive, SE, Clinic GA021
Atlanta, GA 30303
404-616-4600

3. ☐ Immunizations

MMR – Measles (Rubeola), Mumps and Rubella

☐ Documentation of **TWO** MMR Vaccine doses **OR**

☐ Laboratory evidence of immunity to Measles, Mumps and Rubella

VARICELLA (Chicken Pox)

☐ Documentation of **TWO** Vaccine doses **OR**

☐ Laboratory evidence of immunity to Varicella

HEPATITIS B

Required for those at risk of being exposed to blood and body fluids: May include *physician, physician assistant, nurse, emergency medical personnel, dental professional, medical/ nursing/dental student, laboratory technician, nursing assistant, radiology technician, patient care technician, respiratory therapist, medical assistant, physical therapist, pharmacist, EVS, housekeeping, hospital volunteer, patient transporter*)

☐ Laboratory evidence of immunity status

☐ Proof of all Hep B vaccines received

INFLUENZA (FLU) Vaccine required starting in August

☐ Documentation of last Influenza vaccine

☐ **TDAP** within last 10 years

4. ☐ Tuberculosis Screening

☐ Documentation of a **TB blood test** (Quantiferon or T-spot) **within 3 months of your start date** (*no prior TB history only*) **OR**

☐ Chest X-ray less than **3 months old** of start date (*history of positive test without medication treatment or with incomplete treatment only*)

☐ Record of completion of medication treatment for TB if applicable

***PPD skin tests are **not** accepted

5. ☐ Vaccine Exemption Request Form (*Follow instructions on form, Grady only evaluates Grady employees, all others must be approved outside of Grady)*

☐ Not applicable

☐ Attached or will submit

We are by appointment only, please contact 404.616.2500 to schedule yours today

Grady

OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE ☐ NOT REQUIRED

TO THE EMPLOYEE: Are you able to read and understand the questions contained in this evaluation? ☐ Yes ☐ No ☐ Grady ☐ Morehouse ☐ Emory ☐ _______________

Date:_______________ Name_____________________________________ Job Title: __________________________ Age: _____ DOB:___/___/____ Employee ID:_____________

Gender: ☐ Male ☐ Female Height:_____ ft. _____in Weight: _______lbs. Phone number: _____________________________ The best time to phone you:_____________

1. **Has your employer told you how to contact the health care professional who will review this questionnaire?** ☐Yes ☐ No
2. Check the type of respirator you will use (you can check more than one category): ☐ N,R,P disposable respirator (filter-mask, non-cartridge type only). ☐ Other type
3. **Have you worn a respirator (circle one): ☐Yes ☐No If "Yes", what type(s)/size :____**

Yes	No	
		1. Do you currently smoke tobacco or have you smoked tobacco in the last month?
		2. Have you ever had any of the following conditions?
		a. Seizures (fits)
		b. Diabetes (sugar disease)
		c. Allergic reactions that interfere with your breathing
		d. Claustrophobia (fear of closed-in-places)
		e. Trouble smelling odors
		3. Have you ever had any of the following pulmonary or lung problems?
		a. Asbestos
		b. Asthma
		c. Chronic bronchitis
		d. Emphysema
		e. Pneumonia
		f. Tuberculosis
		g. Silicosis
		h. Pneumothorax (collapsed lung)
		i. Lung cancer
		j. Broken ribs
		k. Any chest injuries or surgeries
		l. Any other lung problem that you've been told about
		4. Do you currently have any of the following symptoms pulmonary or lung illness?
		a. Shortness of breath
		b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline
		c. Shortness of breath when walking with other people at an ordinary pace on level ground
		d. Have to stop for breath when walking at your own pace on level ground
		e. Shortness of breath when washing or dressing yourself
		f. Shortness of breath that interferes with your job
		g. Coughing that produces phlegm(thick sputum)
		h. Coughing that wakes you early in the morning
		i. Coughing that occurs mostly when you are lying down
		j. Coughing up blood in the last month
		k. Wheezing
		l. Wheezing that interferes with your job
		m. Chest pain when you breathe deeply

Yes	No	
		n. Any other symptoms that you think may be related to lung problems
		5. Have you ever had any of the following cardiovascular or heart problems?
		a. Heart attack
		b. Stroke
		c. Angina
		d. Heart Failure
		e. Swelling in your legs or feet(not caused by walking)
		f. Heart arrhythmia
		g. High blood pressure
		h. Any other heart problem that you've been told about
		6. Have you ever had any of the following cardiovascular or heart symptoms?
		a. Frequent pain or tightness in your chest
		b. Pain or tightness in your chest during physical activity
		c. Pain or tightness in your chest that interferes with your job
		d. In the past two years, have you noticed your heart skipping or missing a beat
		e. Heartburn or indigestion that is not related to eating
		f. Any other symptoms that you think may be related to heart or circulation problems
		7. Do you currently take medication for any of the following problems?
		a. Breathing or lung problems
		b. Heart trouble
		c. Blood pressure
		d. Seizures
		8. If you've used a respirator, have you ever had any of the following problems? If you've never used a respirator, check the following space ____ and go to question 9
		a. Eye Irritation
		b. Skin allergies or rashes
		c. Anxiety
		d. General weakness or fatigue
		e. Any other problem that interferes with your use of a respirator
		9. Would you like to talk to the health care provider who will review this questionnaire about your answers to this questionnaire?

Employee Signature: **Date:**

EMPLOYEE HEALTH AND WELLNESS CENTER (EHWC) ONLY

Created: 1/21/2021
Updated: 8/16/21, 8/26/21 , 11/22

Follow up Medical Examination ☐Required ☐Not required

Reviewing Physician/Provider Name: Signature: Date:

Facial Hairstyles and Filtering Facepiece Respirators

Intended for workers who wear tight-fitting respirators

RESPIRATOR SEALING SURFACE

Style	Acceptable
CLEAN SHAVEN	✓
STUBBLE	✗
LONG STUBBLE	✗
FULL BEARD	✗
FRENCH FORK	✗
DUCKTAIL	✗
VERDI	✗
GARIBALDI	✗
BANDHOLZ	✗
SOUL PATCH	✓
GOATEE (Careful! Chin hair may easily cross the seal)	
CHIN CURTAIN	✗
EXTENDED GOATEE	✗
CIRCLE BEARD	✗
ANCHOR (Careful! Chin hair may easily cross the seal)	
BALBO (Careful! Chin hair may easily cross the seal)	
VAN DYKE	✗
IMPERIAL	✗
SIDE WHISKERS	✓
MUTTON CHOPS	✗
HULIHEE	✗
HORSESHOE (Careful not to cross the seal)	
ZAPPA	✓
WALRUS	✓
PAINTER'S BRUSH	✓
CHEVRON	✓
HANDLEBAR	✓
PENCIL	✓ ✓
LAMPSHADE	✓
ZORRO	✓
VILLAIN (Careful not to cross the seal)	
WET NOODLE	✗
ENGLISH	✗
DALI	✗

Original image vector by fredrisher/Shutterstock.com

[1]If your respirator has an exhalation valve, some of these styles may interfere with the valve working properly if the facial hair comes in contact with it.
[2]This graphic may not include all types of facial hairstyles. For any style, hair should not cross under the respirator sealing surface.
Source: OSHA Respiratory Protection Standard
https://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=standards&p_id=12716
Further Reading: NIOSH Respirator Trusted-Source Webpage
https://www.cdc.gov/niosh/npptl/topics/respirators/disp_part/respsource3fittest.html

Centers for Disease Control and Prevention
National Institute for Occupational Safety and Health

2017

Tuberculosis Screening Form

Grady Health System
Employee Health and Wellness Clinic
Phone: (404) 616-4600
Email: employeehealth@gmh.edu

☐ Grady ___________________________
☐ Medical School __________________
☐Volunteer ________________________
☐Contract _________________________
Other ______________________________

Name: ____ **Date of Birth:** _________________

Job Title: _______________________ **ID#** ___________________ **MR#** ___________________________

Contact Phone # ______________________ **Work Area/Dept.** __________________ _**Supervisor**________________

All employees must complete this Tuberculosis Screening form annually. Based on your responses a TB blood test and/or a CXR may be required for further evaluation.

1. **Do you have a history of a positive TB test** ___No ___Yes, When?______________
   a. If yes, what test type was positive? ___Skin ___Blood (Quantiferon or T-spot)
   b. Treatment was ___Not offered ___Declined ___Started but not finished ___Completed
2. **Have you ever received BCG vaccine?** ___No ___Yes, When?_____________
3. **Since your last Annual Health Screen have you**? **(Please explain yes answers below**)
   a. Been exposed to someone known or suspected of having TB? ___No ___Yes
   b. Been tested for TB? ___No ___Yes when, where, and what were the results?
   c. Traveled outside of the U.S.? ___No ___Yes where, for how long, and for what purpose?
   d. Been prescribed steroids, "biologics" (for autoimmune diseases), chemotherapy? ___No ___Yes

(Explain yes answers below)

____

____

TUBERCULOSIS SYMPTOMS	ONSET AND DURATION OF SYMPTOMS
1. Cough for ≥ 2 week duration □ yes □ no	
2. Coughing up Blood □ yes □ no	
3. Fever □ yes □ no	
4. Night Sweats □ yes □ no	
5. Unexplained Weight Loss □ yes □ no	**Amount:**
6. Unusual weakness or fatigue □ yes □ no	

Employee Signature____ **Date**________________

Reviewed By: ___________________________ **Signature**___________________________ **Date:** _______________

Mandatory Vaccine Exemption Request Form

As part of its mandatory employment and contracted staff requirements, Grady Health System mandates that all Workforce Members receive certain vaccinations (as listed below) unless the individual qualifies for an authorized exemption. If you have a medical contraindication or religious objection to receiving a mandatory vaccine(s), please use this form to submit your vaccine exemption request(s). Please return the completed form prior to the established mandate deadline to avoid adverse employment or staffing consequences for failure to complying with the mandatory vaccine requirements.

Workforce Member Full Name: ______________________________ Badge ID#: ______________

Date of Birth: ______________________________ Contact #: ______________

Address: ____

____
City State ZIP Code

Grady Affiliation: ☐ Grady Employee ☐ Volunteer ☐ Contract Worker
☐ Resident/Intern ☐ Faculty/Fellow ☐ Student

Work Area and Supervisor's Name (Please print): ______________________________

Human Resources Contact Name (Please print): ______________________________

Mandatory Vaccines: (Please select the vaccine(s) associate with this exemption request)

☐ Influenza** ☐ Hepatitis B ☐ Varicella ☐ Measles, Mumps and Rubella (MMR)

****Flu season is 8/1-3/31**
****Flu vaccine exemption requests are due NO LATER than November 15th EVERY YEAR to be considered (for current employees)**

SELECT YOUR REQUESTED EXEMPTION TYPE BELOW

☐ Medical Exemption Request

If you have a medical contraindication to receiving one of the mandatory vaccine(s), this form MUST be completed, signed and dated by both you and your healthcare provider and returned to Employee Health & Wellness for review and approval of exemption. ***Completed forms should be emailed to employeehealth@gmh.edu*** (for current Workforce Members) and ***ehsonboarding@gmh.edu*** (for new Workforce Members). Submission of the form does not automatically exempt you from receiving the mandatory vaccine(s).

Physician Certification: A physician's signature is required to validate a medical contraindication exemption request(s).

Physician Name (Please Print): ______________________________

Physician Contact Phone Number: ______________________________

My patient has one of the following:

☐ Severe allergic reaction to the following vaccine(s): ______________________________
☐ Guillain – Barré Syndrome
☐ Current Pregnancy (deferral until after pregnancy)
☐ Other medical condition(s) that prevent the safe administration of vaccine(s): ______________________________

____

____

Physician Signature: ______________________________

Date: ______________________________

Form Continues on Page 2

☐ Religious Exemption Request

If you have a religious objection to receiving one of the mandatory vaccine(s), please submit this form and your written religious exemption request directly to the Human Resources Consultant assigned to your department. Exemption request for vaccines will be reviewed by a multi-disciplinary committee for approval. The exemption request must be submitted by the established deadline; submission of a request does not automatically exempt you from receiving the mandatory vaccine(s). ***Completed forms should be emailed to hrservicedelivery@gmh.edu*** for current and new Workforce Members. Submission of the form does not automatically exempt you from receiving the mandatory vaccine(s).

Workforce Member Attestation

I acknowledge that I am aware of the following facts:

- **Due to my occupation as a healthcare worker, I may be at risk of acquiring the influenza infection, COVID-19 infection or other viruses.**
- **Due to my occupation, work location or duties, I may transmit influenza, COVID-19 or other infectious viruses to patients and other health care workers as well as to my family and friends, even though I have no symptoms. This may result in serious health conditions, particularly to those at high risk for infection-associated complications of which I may be one.**
  - **The strains of influenza and COVID-19 virus change frequently, so people who have been infected or given a shot previously may become infected with new strains, therefore the vaccine must be given yearly or as clinically indicated.**
  - **Vaccines are effective in preventing infection of the viruses. Side effects to the vaccines, such as allergic reactions, are infrequent.**
  - **I have received education about the effectiveness of the mandated vaccination(s), as well as possible adverse effects.**
- **I cannot get the influenza disease from the influenza vaccine or COVID-19 from the COVID vaccine.**

I have been given the opportunity to be immunized at no charge to myself. I am requesting, however, an exemption from taking the mandatory vaccine selected above at this time.

I have read and fully understand the information on this form, including the need to submit this completed form by the required deadline. I hereby request an exemption from taking the mandatory vaccine(s). I attest that my exemption rationale is true and correct. I hereby release Grady Health System from any and all claims that may arise from me not receiving the mandatory vaccine(s). I understand that if my request is approved, it is approved for this year's requirement only. Unless I am notified in writing by Employee Health and Wellness that my medical exemption is permanent, a medical exemption for any future years will require the completion and submission of a new form in that applicable year.

Signature: ______________________________ **Printed Name:** ________________________________ **Date** _____________