

**ARCHBOLD MEDICAL CENTER**  
**P.O.Box 1018 \* Thomasville, GA 31799-1018**

Dear Medical Provider,

Archbold Medical Center requires vaccination against COVID-19 as a condition of employment and as required by federal regulation. The individual named above is seeking an exemption to this policy due to medical contraindications. Medical contraindications and precautions for immunization should be based on the most recent recommendations of the Advisory Committee on Immunization Practices/CDC.

Please complete this form to assist Archbold Medical Center in the reasonable accommodation process.

**It is my medical opinion that the person named above should not receive any of the following *COVID-19* vaccinations, *Pfizer, Moderna, or Johnson and Johnson* due to:**

\_\_\_ Severe allergic reaction (e.g. anaphylaxis) after a previous dose or close to a vaccine component. Please provide the dates of allergy testing and the results of such testing:

\_\_\_ Other (explain, attach additional sheets as necessary):

**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 COVID-19 vaccination for the above-named individual.

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