HEALTHTRUST
Workforce Solutions

REQUEST FOR RELIGIOUS EXEMPTION FROM VACCINE PREVENTABLE DISEASE POLICY

As a patient safety and health care personnel safety initiative, Methodist Healthcare System is requiring vaccinations for the following vaccine-preventable diseases: Varicella, Pertussis (TDAP), MMR, Hep B, Influenza, and Tuberculosis. This is similar to other vaccinations that Methodist Healthcare System requires as a condition of employment. Certain vaccinations have been recommended by the Centers for Disease Control for health care personnel and have been shown to be effective in protecting patients from these illnesses and complications related to them. Increasingly, national professional, health care and infection prevention organizations are recommending that health care organizations require certain vaccinations to protect the health and safety of patients, employees, patient and employee family members, and the community as a whole from these diseases.

NAME OF INDIVIDUAL REQUESTING RELIGIOUS EXEMPTION:
_____

Methodist Healthcare System will recognize exemptions to the vaccination policy for religious reasons. The individual identified above is requesting to be exempt from vaccinations for religious reasons. Please confirm that the individual follows religious beliefs that would qualify for an exemption by completing the information below. If you have questions, please contact Director of Employee Health or Designee.

NAME OF RELIGION: _____

NAME AND ADDRESS OF RELIGIOUS ORGANIZATION: _____

DESCRIPTION OF RELIGIOUS DOCTRINE OR PRACTICE THAT IS CONTRARY TO VACCINATIONS:
_____
_____
_____

I certify that the above individual practices a religion where vaccinations are contraindicated according to doctrine or accepted religious practices. I understand that I could be contacted for additional clarification.

NAME OF CLERGY: _____

SIGNATURE OF CLERGY: _____
Signature stamps are not acceptable

I understand I am required to wear Personal Protective Equipment (PPE) at all times during patient care.

DHP Signature _____ Date _____

DHP Name (print) _____