



MEDICAL EXEMPTION FROM COVID-19 VACCINATION

PART 1 – TO BE COMPLETED BY THE EMPLOYEE

Employee Name	Date of Birth	Phone Number
Employer Name	Date of Request	
Please select yes if this exemption is on the basis of pregnancy or anticipated pregnancy. YES <input type="checkbox"/>		

PART 2 – TO BE COMPLETED BY THE EMPLOYEE'S MEDICAL PROVIDER

Employee's Name	
Physician, Physician Assistant, or Advanced Practice Registered Nurse It is my professional opinion as a physician or physician assistant who holds a valid, active license under chapter 458 or chapter 459, Florida Statutes, or an advanced practice registered nurse who holds a valid, active license under chapter 464, Florida Statutes, that COVID-19 vaccination is not in the best medical interest of the employee.	
Medical Provider Signature	Date
Medical Provider Name (print)	Medical Provider License Number

NOTE: Pursuant to section 381.00317(2), Florida Statutes, this completed exemption statement requires the employer to allow the employee to opt-out of the employer's COVID-19 vaccination mandate.