Advocate Health Care
Inspiring medicine. Changing lives.

VACCINATION
REQUEST FOR RELIGIOUS EXEMPTION

Requesting exemption for:

- ☐ **Influenza Vaccination**
- ☐ **Pertussis (Tdap) Vaccination**

Credentialed providers please complete the shaded areas

NAME		**DOB**	/ /
SITE	❑ ACL ❑ Adv at Home ❑ AMG ❑ BROM ❑ CMC ❑ COND ❑ Dreyer ❑ EUR ❑ GSAM ❑ GSHP ❑ IMMC ❑ LGH ❑ SHER ❑ SSH ❑ TRIN ❑ Other:	**LAST 4 DIGITS OF SS#**	
		PAYROLL #	
		HOME PHONE #	( ) -
		WORK PHONE #	( ) -
DEPT		**MANAGER**	

By applying for this Religious Exemption I am attesting that I have a sincerely held religious belief against being vaccinated for the condition identified above. I will make a clear connection between my belief and the vaccination.

Please provide a description below of the religious belief that guides your objection to receiving the vaccination.

<u>There MUST be a clear connection established between the belief and the vaccination.</u>

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My signature below indicates I have provided truthful information above

_____	_____	___/___/___
Associate printed name	Associate signature	Date

ASSOCIATE: RETURN THIS FORM TO YOUR LOCAL EMPLOYEE HEALTH DEPARTMENT, SCAN AND EMAIL TO amg-employeehealth@advocatehealth.com, OR FAX TO (847) 698-4486
PHYSICIAN: RETURN THIS FORM TO YOUR LOCAL SITE'S EMPLOYEE HEALTH DEPARTMENT OR MEDICAL STAFF OFFICE