Healthcare Provider Certification

Attestation

I certify that I have reviewed the Medical Exemption Request completed by

____.
[Student name]

Identify the vaccination for which you recommend exemption: __________________________________

Identify the contraindication or medical condition justifying exemption and explain reason for advising an exemption:

____

____

I am a physician (MD or DO) licensed to practice medicine in a jurisdiction of the United States or an advanced practice nurse licensed in a jurisdiction of the United States.

By signing below, I affirm that I have reviewed the current CDC Contraindications and affirm that the student's stated contraindication is enumerated by the CDC and consistent with established national standards for vaccination practices.

Healthcare Provider Name (please print): ____

Specialty:____

License No.: _____________________ State of Licensure________ NPI No.: ____________________

Phone: ________________Fax:_________________Email:___________________________________

Signature: ____ Date: ___________________
(Note: Signature Stamp Not Acceptable)