FORM III

(Regulation 5A para. 5A(1) and (4))

GOVERNMENT OF ANTIGUA AND BARBUDA

REQUEST FOR MEDICAL EXEMPTION FROM COVID-19 VACCINATION

In accordance with the Public Health Act (Dangerous Infectious Disease) (Amendment) (No. 16) Regulations 2021, the Government of Antigua and Barbuda has mandated that all persons employed:

(a) within the public service;
(b) by or within a Statutory Corporation;
(c) within any company where the Government of Antigua and Barbuda owns a 50% or more share in the business; or
(d) by or with the Customs and Excise Division, Immigration Department, Antigua and Barbuda Police Force, Antigua and Barbuda Defense Force, Office of National Drug and Money Laundering Control Policy (ONDCP), or Port Authority,

shall be required to be vaccinated against COVID-19.

To be considered for an exemption from this requirement, an employee must complete PART 1 of this Form, have a registered and licensed medical practitioner, not related to the employee, complete PART 2. The completed Form shall be submitted by the employee to the Permanent Secretary or Head of Department **in a sealed envelope** addressed to the Chief Medical Officer, Ministry of Health Headquarters, High Street, St. John's, Antigua and Barbuda.

IMPORTANT: A COPY OF THIS PAGE SHALL BE SUBMITTED BY THE EMPLOYEE TO THE PERMANENT SECRETARY OR HEAD OF DEPARTMENT WHO SHALL KEEP THIS PAGE AS PART OF THE EMPLOYEES RECORD.

Note that an employee who receives an exemption shall be required under the provisions of the Public Health Act (Dangerous Infectious Disease) (Amendment) (No. 16) Regulations 2021 to provide a negative test for COVID-19 once in every 14-day period beginning on the 1st day of October, 2021.

PART 1: EMPLOYEE INFORMATION AND CERTIFICATION

Employee Name: ……………………………………………………..…………………

Government Ministry/Department/Statutory Body/Government controlled enterprise:

……………………………………………………………………………………………….

Employee Contact details:

Email address: …………..…………………………..…. Telephone No: ……………………

Initials are required next to each declaration

	I request exemption from the COVID-19 immunization requirements due to my current medical condition/contraindication. I understand and assume the risks of non-immunization. I accept full responsibility for my health, thus removing liability from the Government of Antigua and Barbuda to the required immunization.
	I understand that as I am not vaccinated, in order to protect my own health and the health of the community, I will comply with assigned COVID-19 testing requirements and other preventive guidance including the wearing of masks, physical distancing and social distancing.
	Should I be granted an exemption and I contract COVID-19, I will immediately report it to my supervisor and comply with all isolation and quarantine procedures specified by the Ministry of Health Wellness and the Environment.
	I understand that this exemption will expire when the medical condition(s) contraindicating immunization changes in a manner which permits immunization.
	I understand that this exception is only valid for the approved period, and I may need to submit a new request for any subsequent changes, new medical contraindications, or on expiration of an approved exemption.

I certify that the information I have provided in connection with this request is accurate and complete. I understand this exception may be revoked and I may be subject to disciplinary action if any of the information I provided in support of this exemption is false.

By signing this Form I understand and grant permission for my medical records and information to be shared with the Chief Medical Officer or her designate.

…………………………………………………..… ………………………………………….
Employee Name Employee Signature

……………………………………………….
Date

PART 2: MEDICAL EXEMPTION REQUEST FROM COVID-19 VACCINATION
(To be completed by a registered and licensed medical practitioner in Antigua and Barbuda)

A registered and licensed medical practitioner must complete Section A and where possible, Section B, and provide their provider information in Section C.

SECTION A. Medical Practitioner Certification of Contraindication

I certify that my patient, ……………………………….………. should be exempted from receiving

the ………………………………..COVID-19 vaccine because of the following reason:

☐ Documented severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a component of the …………………………COVID-19 vaccine, including Polyethylene Glycol (PEG). **(Describe reaction/response below and any contraindication to alternative COVID-19 vaccines.)**

☐ Immediate allergic reaction to a previous dose or known (diagnosed) allergy to a component of a COVID-19 vaccine. **(Describe reaction/response below and contraindication to any alternative COVID-19 vaccine.)**

Please note that **NONE** of the following are considered contraindications to the COVID-19 vaccine.

- Local injection site reactions to previous COVID-19 vaccines (erythema, induration, pruritus, pain).
- Expected systemic vaccine side effects in previous COVID-19 vaccines (fever, chills, fatigue, headache, lymphedema, diarrhoea, myalgia, arthralgia.
- Previous COVID-19 infection.
- Vasovagal reaction after receiving a dose of any vaccination.
- Being an immunocompromised individual or receiving immunosuppressive medications.
- Autoimmune conditions.
- Allergic reactions to anything not contained in COVID-19 vaccines, including injectable therapies, food, pets, oral medications, latex etc. (Please note the COVID vaccine does not contain egg or gelatin).
- Alpha-gal Syndrome.
- Pregnancy, undergoing fertility treatment, intention to become pregnant or breast-feeding.
- The medical condition of a family member or other residing in the same household as the employee.

Additional details on the selected option(s) above (to be completed by the medical provider):

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SECTION B. Registered and Licensed Medical Practitioner Certification of Health Condition That Makes COVID-19 Vaccination Detrimental to the Employee's Health

I certify that my patient, ……………………..…….. has the following health condition that prevents him/her from taking the COVID-19 vaccine at this time.

……………………………………………………………………………………………

Additional details on why the health condition[1] listed above prevents him/her from taking the COVID-19 vaccine at this time.

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The patient's health condition as stated above is:

☐ Permanent

☐ Temporary[2], and the expected end date is: ______________________

SECTION C. Registered and Licensed Medical Practitioner Information

☐ ***I certify that the information provided in Part 2 of this form is correct.***

☐ ***I understand that by making a false declaration, I may be subject to disciplinary action as outlined in the Medical Practitioner's Act, 2009.***

Physician's Name: __________________________________

Physician's Phone: __________________________________

Physician's Signature: ______________________ Date of Signature: _______________

Physician's Stamp:

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[1] Supporting documentation should also be submitted or should be readily available.
[2] A new application is required after the expiration date.