



**MEDICAL AND RELIGIOUS WAIVER  
FOR COVID-19 VACCINATIONS**

Name of Employee: \_\_\_\_\_  
(Print)

**Medical Waiver** – I certify that the above employee is under my medical care and should be exempt from receiving the Covid-19 vaccination due to medical reason(s). This must be renewed annually.

\_\_\_\_\_  
Physician Name (Print) Physician Signature Date  
\_\_\_\_\_  
Phone Number Fax Number  
\_\_\_\_\_  
Address City State Zip

**Religious Waiver** – I certify that the above employee should be exempt from receiving the Covid-19 vaccination due to religious belief. This need not be renewed annually.

\_\_\_\_\_  
Religious/Spiritual Leader Name (Print) Religious/Spiritual Leader Signature Date  
\_\_\_\_\_  
Phone Number Fax Number  
\_\_\_\_\_  
Address City State Zip

\_\_\_\_\_  
Signature of Employee Date

Employee should submit completed form to [CCLS\\_HR\\_support@cclswi.org](mailto:CCLS_HR_support@cclswi.org).