Dear NYP Supplier Representative,

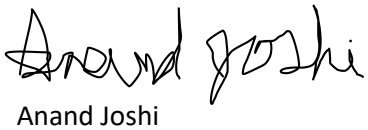
Effective September 1, 2021, NewYork-Presbyterian will require all vendors that come onsite to be vaccinated against COVID-19 or to obtain a valid exemption. This will be in addition to our existing vaccination requirements against influenza, measles, rubella, and varicella. As a leading health care organization, we believe it is essential to require vaccinations to protect patients, visitors, employees, vendors, and ourselves against the threat of further harm from the pandemic and the possibility of more dangerous mutations. Since vaccinations against COVID-19 were introduced, more than 2.25 billion doses have been administered worldwide - including 300 million in the U.S. - and more than 50% of the eligible U.S population is fully vaccinated. The vaccines have proven to be safe and highly effective in preventing hospitalizations, death, and spread of the virus.

All vendors that plan to come onsite to NYP facilities must have received their first dose of a COVID-19 vaccine no later than September 1, 2021, and, for two-dose vaccines, they must complete the vaccination process on the prescribed timeline. We expect you to follow all relevant NYP policies and procedures. NYP will recognize valid medical and religious exemptions in accordance with the standards set forth in our policy; to qualify, your company must put in place a process to review and validate the requests being submitted from individuals which must include documentation from a physician for medical exemptions and/or detailed requests for religious exemptions. We have included in this communication template letters that can be utilized for both of these exemptions.

Any individuals who receive an exemption from COVID-19 vaccination will be required to get tested every seven days and provide evidence of negative tests results. Requests for exemption and subsequent testing results should be maintained for your organization as documentation that you are following our policies and procedures in the event NYP audits compliance.

If you have any questions or concerns about the above request please feel free to contact me directly via e-mail. Our top priority remains the safety of our patients, staff, visitors and supplier representatives who are in our hospitals.

Best regards,



Anand Joshi
VP, Procurement and Strategic Sourcing
Asj9001@nyp.org

Request for Medical COVID-19 Immunization Exemption Form	Name	Company
	Direct/Mobile Phone	Date of Birth
	Email	Job Title

INSTRUCTONS: A medical exemption may be granted upon receipt of a completed form (below) not more than 6 months old, signed and certified by a licensed healthcare provider, not related to the submitter, and whose specialty is appropriate to the associated condition. Medical exemptions expire when the medical condition(s) contraindicating COVID-19 immunization changes in a manner that permits immunization. Individuals with an approved exemption may be required to comply with additional testing and other preventive requirements.

By signing below, I hereby certify that the below information provided is true and correct to the best of my knowledge. I understand any false information will disqualify any prior approval.

Employee's Signature:_____ **Date:** _____/_____/_____

TO BE COMPLETED BY YOUR PHYSICIAN:

Attention Health Care Provider:

_____ (insert patient's name) is requesting a medical exemption from a vaccination requirement. A medical exemption may be allowed for certain recognized contraindications. Please certify the medical reason that your patient should not be immunized for COVID-19 by completing this form and attaching available supporting documentation.

(Continue to next page)

Option 1 - Allergy

__ A documented history of a severe allergic reaction to any component of a COVID-19 vaccine or to a substance that is cross-reactive with a component. Please indicate which of the following vaccines are contraindicated and name the components, by vaccine NOTE: since egg-free vaccine is available, history of egg allergy will not be accepted as a routine medical exemption.

• Moderna - List the component(s): _____

• Pfizer - List the component(s): _____

• Janssen/Johnson & Johnson - List the component(s): _____

__ A documented history of a severe allergic reaction after a previous dose of the COVID-19 vaccine.

Please indicate to which vaccine the patient had a reaction, and the date of the vaccine and reaction.

• Moderna - Date of Vaccine & Reaction: _____

• Pfizer - Date of Vaccine & Reaction: _____

• Janssen/Johnson & Johnson - Date of Vaccine & Reaction: _____

Option 2 – Physical Condition/Medical Circumstance

__ The physical condition of the patient or medical circumstances relating to the individual are such that immunization is not considered safe. Please state, with sufficient detail for independent medical review, the specific nature and probable duration of the medical condition or circumstances that contraindicate immunization with the COVID-19 vaccine:

_____

_____

Option 3 - Other

__ Other. Please provide this information in a separate narrative that describes, in detail, the medical condition or disability in detail that you opine would exempt this individual from vaccination:

Explanation: _____

_____

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Health Care Provider Certification

I certify that _____ (patient name) has the above contraindication and support the request for a medical exemption from a COVID-19 vaccine requirement.

Provider Information

Medical Provider Name	
Medical Provider Specialty	
Medical Provider Signature	
Medical Provider License Number	
Date	
Name of Medical Provider's Company	
Email	
Phone Number	

Request for Religious COVID-19 Immunization Exemption Form	Name	Company
	Direct/Mobile Phone	Date of Birth
	Email	Job Title

INSTRUCTIONS: An exemption may be granted if the individual holds a genuine and sincere religious/deeply held belief which is contrary to the practice of immunization.

Individuals with an approved exemption may be required to comply with COVID-19 testing and other preventive requirements.

Please describe your religious/deeply held belief and how it relates to the COVID vaccination.

By signing below, I hereby certify that the above information provided is true and correct to the best of my knowledge. I understand any false information will disqualify any prior approval.

Employee's Signature:_____

Date:_____/_____/_____

Company Management Signature:_____

Date:_____/_____/_____