CDSS
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DEPARTMENT OF SOCIAL SERVICES
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COVID-19 Vaccination Exemption Form

Provider Name (Print):
Provider Number (9 digits):

Pursuant to State of California Public Health Officer Order dated September 28, 2021, the California Department of Public Health (CDPH) is mandating that employees who provide In-Home Supportive Services (IHSS) or Waiver Personal Care Services (WPCS) to any recipient that is not a family member or does not live with their provider, to provide proof of complete COVID-19 vaccination by November 30, 2021. Please give a copy of your completed form to your recipient(s) and keep a copy for your records.

Vaccine Exemption

☐ I am excused from receiving a COVID-19 vaccine for a qualifying medical reason. *NOTE*: To be eligible for this exemption, I understand that I must also obtain a written statement signed by a **physician**, **nurse practitioner**, or **other licensed medical professional practicing under the license of a physician**, stating that I qualify for the exemption (but the written statement should not describe the underlying medical condition or disability) and indicating the probable duration of my inability to receive the vaccine (or if the duration is unknown or permanent, so indicate).

☐ Religious Belief Accommodation: I have a sincerely held religious belief, practice, or observance that prevents me from receiving any of the COVID-19 vaccines.

Signature and Attestation

I understand that, if I meet the requirements of a religious or medical exemption, I will be subjected to mandatory weekly COVID-19 testing and I will wear a surgical mask or higher-level respirator approved by the National Institute of Occupational Safety and Health (NIOSH), such as an N95 filtering facepiece respirator, consistent with the September 28, 2021 CDPH Public Health Order.

By signing below, I hereby declare and acknowledge that I have read and fully understand the information in this exemption form and certify under penalty of perjury that the information I have provided in this exemption form is true and correct. I understand that recipients I provide services to may choose to no longer have me provide them services because I have chosen not to get the COVID-19 vaccine.

Signature:_____ Date:_____