GOVERNMENT OF ST. VINCENT AND THE GRENADINES

PUBLIC HEALTH (PUBLIC BODIES SPECIAL MEASURES) RULES 2021
CERTIFICATE OF MEDICAL PRACTITIONER UNDER RULE 7(1) (a)
FOR MEDICAL EXEMPTION

PERSONAL INFORMATION OF EMPLOYEE

NAME (Please Print):........................................................................................................................................................................

TITLE:  [ ] MR.  [ ] MRS.  [ ] MS.

POST: ........................................................................................................................................................................................................

MINISTRY/DEPARTMENT/OTHER:....................................................................................................................................................

ADDRESS: ................................................................................................................................................................................................

CONTACT INFORMATION:

TELEPHONE:  Home: ......................... Cell: ........................................... Work: ...........................................................

EMAIL ADDRESS: ..................................................................................................................................................................................

DECLARATION BY EMPLOYEE:

I, the undersigned, hereby declare that the information provided above is correct.

Signature: ................................................................. Date: .................................................................
CERTIFICATE OF MEDICAL PRACTITIONER

NAME OF MEDICAL CLINIC: ………………………………………………………………………………………………………………………………

ADDRESS: ………………………………………………………………………………………………………………………………………………………

NAME OF MEDICAL PRACTITIONER: …………………………………………………………………………………………………………………

QUALIFICATIONS: …………………………………………………………………………………………………………………………………………………

POSITION: ……………………………………………………………………………………………………………………………………………………………

CONTACT INFORMATION:

TELEPHONE:  Home: ……………………… Cell: ……………………… Work: ………………………………………………………………………

EMAIL ADDRESS: …………………………………………………………………………………………………………………………………………………

CERTIFICATION BY MEDICAL PRACTITIONER:

I, the undersigned, hereby certify that it is not advisable to vaccinate the patient named above on the following medical grounds:

☐ Severe allergic reaction (anaphylaxis) after a previous dose or to a component of all of the COVID-19 vaccines, including Polyethylene Glycol (PEG).

☐ Immediate allergic reaction to previous dose or known (diagnosed) allergy to a component of all of the COVID-19 vaccines.

☐ Temporary medical exemption to receiving dose 1 ☐ dose 2 ☐ of any of the COVID-19 vaccines due to:

☐ Acute major illness, being………………………………………………………………………………………………………………………………

☐ Significant immunocompromise of short duration, being……………………………………………………………………………………

☐ Past confirmed infection with SARS-CoV-2 within the last 4 weeks.

Date of diagnosis _ _/_ _/_ _

☐ Another specified temporary medical contraindication, being……………………………………………………………………

Signature: …………………………………………………………… Date: ………………………………………………………………………

PLEASE NOTE THE FOLLOWING:

This certificate shall be accompanied by a detailed report and supporting evidence from a medical practitioner approved by the Medical Officer of Health