

Te Marae Ora Cook Islands Ministry of Health

**COVID-19 Vaccine Temporary Medical Exemption Application Form**

Please send the completed application to covidvacmedexemption@cookislands.gov.ck

Completed applications will be processed within 10 working days.

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| **Consumer Details** |
| Full Name |  |
| Contact Phone number |  |
| Contact Address |  |
| Contact Email |  |
| Address  |   |
| Vaccine Order Status  | Yes[ ]  or No[ ]  | Date of Birth |  |
| NHI |  |
| I [ ], consumer, certify that the information I have provided to the practitioner for the purposes of making this application is true. |
| Consumer Signature |  | Date Signed |  |
| **Applicant Details** |
| Full Name |  |
| Contact Phone number |  |
| Contact Email |  |
| Clinic Address |  |
| Registration number |  |
| Category exemption criteria(please tick those that apply) | [ ] 1A[ ] 1B (4 of 4 criteria required)[ ] 1C | [ ] 2A [ ] 2B | [ ] 2C[ ] 2D  | [ ] 3A  |
| The duration of the clinical relationship with the consumer is \_\_\_\_\_\_\_\_ years \_\_\_\_\_\_ months 1 |
| I [ ] medical practitioner certify that I:Have reviewed the consumer’s medical history and assessed the person’s state of health.  Yes / No Have clinical evidence supporting the person meets the specified COVID-19 vaccination exemption criteria. Yes / No |
| The attached supporting clinical evidence is: |
| I certify that I provide this information believing it to be true. |
| Applicant Signature |  | DateSigned |  |