

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.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **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 |  | | | Date  Signed | |  | |