GOVERNMENT OF GUAM
DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES
DIPATTAMENTON SALUT PUPBLEKO YAN SETBISION SUSIAT

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MEDICAL EXEMPTION FOR COVID-19 VACCINATION

Name of Client: _____ Date of Birth: _____

Place of Employment: _____

☐ TEMPORARY MEDICAL EXEMPTION (**An expiration date is required to be valid**.)

☐ PERMANENT MEDICAL EXEMPTION (An expiration date is NOT required.)

Please indicate which vaccine(s) the medical exemption is referring to:

COVID-19 Vaccine (**Please specify**): Expiration Date: _____

☐ Pfizer ☐ Moderna ☐ Johnson & Johnson

Please describe the patient's contraindication(s)/precautions here: _____

_____

_____

_____

Licensed Physician's Official Stamp and contact information:

Physician's Signature:

_____

Guam Medical License #: _____

Date: _____

DO NOT MARK BELOW THIS LINE (For DPHSS Use ONLY)

Medical Exemption Status: ☐ Approved ☐ Disapproved

Comments: _____

_____

_____ _____

ROBERT LEON GUERRERO, MD Date
Interim Chief Medical Officer
Department of Public Health and Social Services

Document No. _____