Ministry of Health Application

COVID-19 Vaccine Temporary Medical Exemption

Please send the completed application to temporarymedicalexemption@health.govt.nz

Consumer Details			
Full Name			
Contact Phone			
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				
Contact Email				
Clinic Address				
Registration number				
Health Practitioner Index 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				
I [ ] nurse practitioner/medical practitioner [select] 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	