

**Appendix D: Temporary Waiver from Weekly COVID-19 Testing on the Basis of Prior COVID-19 Infection**

Pursuant to Executive Order No. 13G, Covered State Agencies, School Boards, or Child Care Facilities may allow individuals who are not fully vaccinated to continue to access on-site facilities only if the individual:

- 1) is able to perform their essential job functions with a reasonable accommodation that is not an undue burden on the facility,
- 2) does not pose a direct threat to the health or welfare of others, and
- 3) submits adequate proof of a negative test for SARS-CoV-2 on a weekly basis

CDC recommends that individuals who have **had documented COVID-19 within the prior 90 days** should not be included in screening testing programs for asymptomatic people. This is because some components of viral RNA may remain present in a COVID-19 recovered person’s body for up to 90 days, and as a result cause a person to test positive for SARS-CoV-2 even when they are not actively infected (i.e., false positives). Individuals who are experiencing symptoms of COVID-19 who have been infected in the prior 90 days should consult with their healthcare provider regarding the utility of SARS-CoV-2 testing.

If you are a state employee or other covered worker subject to the provisions of Executive Order No. 13G, you may request a temporary waiver from the weekly SARS-CoV-2 testing portion of the Executive Order requirements for the 90 days after your COVID-19 diagnosis. To request this waiver, individuals must have their healthcare provider complete the information below and both you and your healthcare provider must attest to the accuracy of the information provided. Once the form is completed, please submit it to the individual designated by the facility to receive this request.

**EMPLOYEE REQUESTING EXEMPTION:**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Job Title: \_\_\_\_\_ Employee Number: \_\_\_\_\_

Agency/Department: \_\_\_\_\_

Manager/Supervisor: \_\_\_\_\_

Email: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

## HEALTHCARE PROVIDER CERTIFICATION

**Patient Name:** \_\_\_\_\_

### Dear Healthcare Provider:

The above-named individual has requested to be temporarily excused from SARS-CoV-2 testing, as required by their employer under the Governor's Executive Order No. 13G, on the basis of having had COVID-19 within the prior 90 days. This request for a temporary waiver will be evaluated based on the information you provide.

Please complete this form if the person listed above seeking a temporary waiver from SARS-CoV-2 testing is your patient and you can positively attest that this patient had COVID-19 at some point in the prior 90 days. More information on recommendations for SARS-CoV-2 testing, including under what conditions testing is or is not recommended, can be found on the CDC website:  
<https://www.cdc.gov/coronavirus/2019-ncov/hcp/testing-overview.html>.

### Directions:

**Part 1.** Please complete the Provider Information requested.

**Part 2.** Please mark the applicable basis for your recommendation for a temporary waiver for this patient, and the date of diagnosis and applicable date of expiration of the waiver.

**Part 3.** Read, sign, and date the Statement of Clinical Opinion.

### Part 1. Provider Information:

**Physician (MD or DO)/Physician Assistant/Nurse Practitioner (APRN) Name (print):**

\_\_\_\_\_

**Name and Address of Practice:**

\_\_\_\_\_

**Contact Phone Number:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**State License Number:** \_\_\_\_\_