TEMPORARY WAIVER FROM WEEKLY COVID-19 TESTING ON THE BASIS OF PRIOR COVID-19 INFECTION APPLICATION

The 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 of the 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 COVID-19 even when they are not actively infected (i.e., false positives). Individuals who are experiencing symptoms of COVID-19 who are experiencing symptoms should consult with a healthcare provider.

Employees may request a temporary waiver from the weekly COVID testing portion of the Mandatory Vaccination/Weekly Testing Policy requirements for the **90 days after a COVID diagnosis.** To request this temporary waiver, individuals must have their healthcare provider complete the information on this application/form. Both the employee and the healthcare provider must attest to the accuracy of the information provided. Once the form is completed, please submit to Human Resources and/or the Human Capital Office within the Department of Education in one of the following ways:

Human Resources *(Blue Collar, WCEA, WMAA, CSEA, CHCA School Nurses)*	**Human Capital Office with Department of Education** *(SAW, WTA, UPSEU Units 68 & 69, non-union employees assigned to work in schools)*
Email: hr@waterburyct.org	Email: Covidstaffinquiry@waterbury.k12.ct.us
Fax: 203-574-8087	Fax: 203-346-3513

Name:__________________________________ Date of Birth: __________________

Job Title:_____________________________ Employee Number:________________

School/Department:____

Supervisor:____

Email:______________________________________ Phone:_____________________

HEALTHCARE PROVIDER CERTIFICATION

Patient Name____

Dear Healthcare Provider:

The above-named individual has requested to be temporarily excused from weekly COVID 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 that you provide.

Please complete this form if the person listed above seeking a temporary waiver from weekly COVID testing is your patient and you can positively attest that this patient had COVID-19 at some identifiable point in the past 90 days.

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's Assistant/Nurse Practitioner (APRN) Name (print)**:**

____

Name and Address of Practice:

____

Contact Phone Number:___________________ **email:** ______________________

State License Number: ____

Patient Name____

Part 2. Basis of Verification of Patient's Current or Prior COVID Status

In this section, indicate the basis on which you can affirmatively verify that the individual requesting this temporary waiver has had an active COVID infection within the prior 90 days.

Please check off any of the following that apply:

____ I have verified that this individual had a positive test for COVID performed by, and the result reported by, as state licensed clinical laboratory, pharmacy-based testing provider, or other healthcare provider facility within the prior 90 days.

____ I had diagnosed this individual with COVID within the prior 90 days based on his/her symptom presentation and history of close contact with another COVID case.

____ I had diagnosed this individual with COVID within the prior 90 days on some other clinical basis, which I will specify below (must explain below):

____

Date of COVID-19 Diagnosis: __________________________

Date of Waiver Expiration: _______________________ (90 days after date listed above)

Part 3. Statement of Clinical Opinion

Your Signature below indicates agreement with the following statement:

PROVIDER CEERTIFICATION: In accord with the legal requirements of Executive Order 13G, I certify that the above-named individual should be granted a temporary waiver from weekly COVID-19 testing based on their having had COVID-19 within the prior 90 days. I understand that it is a crime under Connecticut State Law to provide false information in response to the provisions of Executive Order 13G, punishable pursuant to Section 53a-157b of the General Statutes by a fine of not more than $2,000 or imprisonment of not more than one year.

Signature: ______________________________________ **Date:**______________