ᑲᑐᑎᓪᓗᒋ ᓄᓇᕗᑦ ᐱᕈᖅᐸᓪᓕᐊᑎᓪᓚᕗᑦ
Building Nunavut Together
Nunavuliuqatigiingniq
Bâtir le Nunavut ensemble

Attach patient sticker below or complete:

Patient Name: ________________________
(Last Name) (First Name)

DOB: ___________ (DD/MM/YY) Age: ______

Gender: M / F / U NU MRN#: ___________

I,___________________________________(physician name), certify that, for medical reasons, the above-named individual is TEMPORARILY unable to receive a COVID-19 immunization with the current COVID-19 vaccines available in Nunavut (Pfizer-BioNTech COMIRNATY® COVID-19 vaccine, Moderna SPIKEVAX® COVID-19 vaccine).

This individual received a monoclonal antibody infusion for the treatment of COVID-19 and is contraindicated to vaccine within the first 90 days. After 90 days from the infusion date, the patient has NO EXEMPTION to receive a Health Canada approved vaccination, unless there is another pre-existing exemption from another provider.

Length of Exemption: 90 days

From: To:

_____/____/____ _____/____/____
YYYY/MM/DD YYYY/MM/DD

Name: ___________________________________

Signature: ________________________________

Date: ____________________________________

Licence No: _____________________