Temporary Waiver from Weekly COVID-19 Testing on the Basis of Prior COVID-19 Infection

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,
you may request a temporary waiver from the weekly SARS-CoV-2 testing
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: _____

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DEPARTMENT OF ADMINISTRATIVE SERVICES

HEALTHCARE PROVIDER CERTIFICATION

Patient Name: _____

Dear Healthcare Provider:

The above-named individual has requested to be temporarily excused from SARS-CoV-2 testing, 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: _____

Patient Name: _____

Part 2. Basis of Verification of Patient's Current or Prior COVID-19 Status

In this section, indicate the basis on which you can affirmatively verify that the individual requesting this temporary waiver has had an active SARS-CoV-2 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 SARS-CoV-2 performed by, and the result reported by, a state licensed clinical laboratory, pharmacy-based testing provider, or other appropriate healthcare provider facility within the prior 90 days

☐ I had diagnosed this individual with COVID-19 within the prior 90 days based on his or her symptom presentation and history of close contact with another COVID-19 case

☐ I had diagnosed this individual with COVID-19 within the prior 90 days on some other clinical basis (must specify below):

_____

Date of COVID-19 diagnosis: _____

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

If you have filed for a medical or religious exemption, you are not considered compliant until that exemption is officially approved upon review. In the interim, you must submit weekly testing results.

PLEASE NOTE: ONLY state employees with a state Employee ID #, or others with specific direction (please see portal.ct.gov/sevi) can submit information to WellSpark. State contractors do not submit forms to WellSpark. If you are a **state employee with a state employee ID number**, without computer or smartphone access, you can submit your information via email at statecovid@wellsparkhealth.com or fax to 860-678-5207 or 860-678-5229. Please include proof of complete or partial vaccination with this form. All others without smartphone or computer access should consult with their supervisor or human resources department to submit required proof of vaccination and attestation documentation.

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Part 3: Statement of Clinical Opinion

Your signature below indicates agreement with the following statement:

PROVIDER CERTIFICATION:

I certify that the above-named individual should be granted a temporary waiver from SARS-CoV-2 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 punishable pursuant to Section 53a-157b of the Connecticut General Statutes by a fine of not more than $2,000 or imprisonment of not more than one year.

Signature: _____ **Date:** _____