North Carolina Department of Health and Human Services
Women's and Children's Health Section ▪ Immunization Branch

# NC PHYSICIAN'S REQUEST FOR MEDICAL EXEMPTION FORM DHHS 3995

**Purpose:** To provide physicians licensed to practice medicine in North Carolina with a mechanism to request a medical exemption to a required immunization(s), pursuant to G.S. 130A-156, for a contraindication not adopted by the NC Commission for Public Health under 10A NCAC 41A .0404 and, therefore, not included on the NC Medical Exemption Statement Form DHHS 3987. Physicians shall state the specific vaccine(s) the individual should not receive, the basis of the request, and the length of time the requested exemption will apply for the individual. This request is subject to review by the State Health Director. The State Health Director may grant or deny a medical exemption to the requested vaccine(s). Additional copies of this form and the NC Medical Exemption Statement Form DHHS 3987 can be accessed at: https://www.immunize.nc.gov/schools/ncexemptions.htm

**INSTRUCTIONS**

1. Complete and sign the form.
2. Provide documentation necessary to support the request (clinic notes, labs, etc.).
3. **Attach a copy of the most current immunization record.**
4. Retain a copy for the patient's file.
5. Provide a copy to the person requesting the medical exemption.
6. Send the completed form, supporting documentation and the current immunization record to:

NC Department of Health and Human Services
Division of Public Health
Immunization Branch
1917 Mail Service Center
Raleigh, NC 27699-1917

Name of Patient _____DOB _____

Name of Parent/Guardian _____ Primary Phone (  ) _____

Home Address (Patient/Parent) _____County_____

Name of Child Care/School/College/University _____

| **Please mark the vaccine(s) that the proposed medical exemption(s) applies to:** | | |
|---|---|---|
| ☐ DTaP | ☐ MMR | ☐ Hepatitis B |
| ☐ Tdap | ☐ Varicella | ☐ Haemophilus influenza type B (HiB) |
| ☐ DT/Td | ☐ IPV | ☐ Meningococcal Conjugate (MenACWY) |
| ☐ Pneumococcal Conjugate (PCV13) | | |

**For each vaccine marked above, please describe the contraindication(s) and the proposed length of time that would apply (attach additional pages if necessary): _____**

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**A physician (M.D. or D.O.) licensed to practice medicine in NC must complete and sign this form.**

N.C. Physician's Name (please print) _____ Phone _____

Mailing Address _____

N.C. Physician's Signature _____ Date _____

**For questions, please contact the North Carolina Immunization Branch Nurse Call Line at (919) 707-5575.**