Applicant Details	
Full Name	
Contact Phone number	
Contact Email	
Clinic Address and Country	
Registration number	
Health Practitioner Index Number (or international equivalent)	

Category exemption criteria (please tick those that apply)	☐ 1A ☐ 1B ☐ 1C	☐ 2A	☐ 3A ☐ 3B ☐ 3C	☐ 4A

The duration of the clinical relationship with the consumer is ______ years _____ months

I [ ] nurse practitioner/medical practitioner [select] certify that I:

Have reviewed the consumer's medical history and assessed the person's state of health.
Yes / No

Have clinical evidence supporting the person meets the specified COVID-19 vaccination exemption criteria.
Yes / No

Has the consumer been previously granted a Temporary Medical Exemption in New Zealand?
Yes / No / Don't Know

For a 1A application, have sighted a positive PCR or a verified Rapid Antigen Test result.
Yes / No

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The attached supporting clinical evidence is:

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I certify that I provide this information believing it to be true.

Applicant Signature		Date Signed	

END

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