Student/Faculty Request for Medical Exemption from Vaccination

Name: _____ Date: _____

School: _____ Position/Role: Student/Faculty (circle one)

Dear Medical Provider,

This Student/Faculty is seeking an exemption due to medical contraindications per the CMS Omnibus COVID-19 Health Care Vaccination Rule.

Please complete this form to assist us in the reasonable accommodation process.

The person name above should not receive the COVID-19 vaccine due to (select below):

☐ Specify which of the COVID-19 Vaccines is clinically contraindicated for this person:

_____

☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to component of the COVID-19 vaccine

☐ Immediate (within 4 hours of exposure) allergic reaction of any severity to a previous doe or known (diagnosed) allergy to a component of the vaccine

☐ Another medical condition or disability (please specify):

_____

_____

I certify the above information to be true and accurate, and request exemption from COVID-19 vaccination for the above-named individual. I am a licensed healthcare provider who is providing this person with ongoing medical care and treatment related to the medical contraindications described above.

Medical Provider Name	Medical License #
Medical Provider Signature:	Date of signature:
Practice Name & Address:	Provider Phone: