COVID-19 Vaccination Employee Medical Exemption Application

Directions: Please complete and sign Section 1. Section 2 must be signed by a physician (MD or DO), nurse practitioner, or physician. (**Please note: The nurse practitioner at the Wellness Center CANNOT sign this form.**) Please email the competed form to covidexemptions@converse.edu.

PLEASE NOTE: This form is an application for an exemption. This exemption must be approved by the University. You will receive an email containing your final approval.

SECTION 1: COVID-19 Vaccine Declination Statement

Employee name: _____

Date of birth: _____

Please mark the medical concern that prevents you from receiving the COVID-19 vaccine:

☐ History of previous allergic reaction to indicate an immediate hypersensitivity reaction to a component of the vaccine

☐ A physical condition or medical circumstances that prevent me from being safely vaccinated—please describe:

☐ Other—please describe: _____

Please indicate if the exemption is: ☐ permanent OR ☐ temporary (please list exemption end date: _____)

I understand that I will be required to follow University policies and procedures regarding risk mitigation (e.g., masking, testing, isolation, quarantine, etc.) In the event that I am required to enter isolation or quarantine, I understand that I will be temporarily removed from all campus activities including on-campus work until my isolation or quarantine period is complete. The duration of any quarantine or isolation periods will be in accordance with CDC guidance and University policy.

_____ _____

Employee signature *Date*

SECTION 2: Medical provider declaration statement (*Must be completed and signed by a medical provider as listed above*)

Medical provider name: _____

Practice address: _____

Practice phone number: _____

License number: _____ State of licensure: _____

By signing below, I am affirming the presence of the medical concern that this individual has listed above. I am certifying that the physical condition of this individual is such that the COVID-19 vaccination would endanger their life or health; as such, the risks created by vaccination outweigh the potential benefits of preventing serious illness due to COVID-19.

_____ _____

Medical provider signature *Date*