University of California **Medical Exemption Request Form**

BERKELEY • DAVIS • IRVINE • LOS ANGELES • MERCED • RIVERSIDE • SAN DIEGO • SAN FRANCISCO • SANTA BARBARA • SANTA CRUZ

Full Name of Student: ______________________________

Campus Student Attends: ______________________________

Student's Medical Record Number: ______________________________

Student's Date of Birth: ______________________________

I, ______________________________ [Name of licensed MD, DO, PA, NP] have reviewed the University of California Immunization Exemption Policy, and hereby certify that the above-named student has:

☐ A medical condition that contraindicates his/her vaccination with ______________________________ vaccine:
Please check the appropriate box and list below either: (list only 1 vaccine per section)

a) ☐ The applicable CDC contraindication to this vaccine*, or
b) ☐ The applicable manufacturer's vaccine insert contraindication to this vaccine*, or
c) ☐ The physical condition of the person or medical circumstances relating to the person that are such that immunization is not considered safe, indicating the specific nature of the medical condition or circumstances* that contraindicate immunization with this vaccine*

*REQUIRED: **Description of contraindication meeting criteria a, b, or c above:**

____

____

____

____

This contraindication is: ☐ Permanent or ☐ Temporary

If temporary: The expiration date of the exemption for this vaccine is: ______________________________

Titers for immunity to this disease: (Please attach photocopies of any titer results if done)

☐ Indicate that he/she is immune ☐ Indicate he/she is NOT immune ☐ Have not yet been obtained

☐ A medical condition that contraindicates his/her vaccination with ______________________________ vaccine:
Please check the appropriate box and list below either: (list only 1 vaccine per section)

a) ☐ The applicable CDC contraindication to this vaccine*, or
b) ☐ The applicable manufacturer's vaccine insert contraindication to this vaccine*, or
c) ☐ The physical condition of the person or medical circumstances relating to the person that are such that immunization is not considered safe, indicating the specific nature of the medical condition or circumstances* that contraindicate immunization with this vaccine*

*REQUIRED: **Description of contraindication meeting criteria a, b, or c above:**

____

____

____

____

This contraindication is: ☐ Permanent or ☐ Temporary

If temporary: The expiration date of the exemption for this vaccine is: ______________________________

Titers for immunity to this disease: (Please attach photocopies of any titer results if done)

☐ Indicate that he/she is immune ☐ Indicate he/she is NOT immune ☐ Have not yet been obtained

☐ A medical condition that contraindicates his/her vaccination with ______________________ vaccine:

Please check the appropriate box and list below either: (list only 1 vaccine per section)

a) ☐ The applicable CDC contraindication to this vaccine*, or
b) ☐ The applicable manufacturer's vaccine insert contraindication to this vaccine*, or
c) ☐ The physical condition of the person or medical circumstances relating to the person that are such that immunization is not considered safe, indicating the specific nature of the medical condition or circumstances* that contraindicate immunization with this vaccine*

***REQUIRED: Description of contraindication meeting criteria a, b, or c above:**

____

____

____

____

This contraindication is: ☐ Permanent or ☐ Temporary

If temporary: The expiration date of the exemption for this vaccine is: ______________________

Titers for immunity to this disease: (Please attach photocopies of any titer results if done)

☐ Indicate that he/she is immune ☐ Indicate he/she is NOT immune ☐ Have not yet been obtained

☐ A medical condition that contraindicates his/her vaccination with ______________________ vaccine:

Please check the appropriate box and list below either: (list only 1 vaccine per section)

a) ☐ The applicable CDC contraindication to this vaccine*, or
b) ☐ The applicable manufacturer's vaccine insert contraindication to this vaccine*, or
c) ☐ The physical condition of the person or medical circumstances relating to the person that are such that immunization is not considered safe, indicating the specific nature of the medical condition or circumstances* that contraindicate immunization with this vaccine*

***REQUIRED: Description of contraindication meeting criteria a, b, or c above:**

____

____

____

____

This contraindication is: ☐ Permanent or ☐ Temporary

If temporary: The expiration date of the exemption for this vaccine is: ______________________

Titers for immunity to this disease: (Please attach photocopies of any titer results if done)

☐ Indicate that he/she is immune ☐ Indicate he/she is NOT immune ☐ Have not yet been obtained

Signature of Medical Provider:	Date:	Medical License Number & State/Country of Issue:
Practice Address:		Provider Phone Number & Email:

Students: Return this completed form to the Student Health Service at the UC campus where you attend.

For Use by University of California Student Health Staff Only:	Campus: ______________
☐ Date Approved: ______________	Address: ______________
☐ Date Denied: ______________	______________
☐ Date of Entry into PnC: ______________	______________

UNIVERSITY OF CALIFORNIA
MEDICAL EXEMPTION AND/OR DISABILITY EXCEPTION REQUEST FORM
Exception to SARS-CoV-2 (COVID-19) Vaccination Requirement

EMPLOYEE OR STUDENT NAME	EMPLOYEE OR STUDENT ID
JOB TITLE (IF APPLICABLE)	LOCATION
DEPARTMENT	SUPERVISOR (IF APPLICABLE)
PHONE NUMBER	EMAIL

This form should be used by University employees and students to request an Exception to the COVID-19 vaccination requirement in the University's SARS-CoV-2 Vaccination Program Policy based on (a) Medical Exemption due to a Contraindication or Precaution to COVID-19 vaccination recognized by the U.S. Centers for Disease Control and Prevention (CDC) or by the vaccines' manufacturers or (b) Disability.

Fill out Part A to request an Exception based on Medical Exemption. Fill out Part B to request an Exception based on Disability. Both sections may be completed if both apply to you. Important: Do not identify any diagnosis, disability, or other medical information. That information is not required to process your request.

Part A: Request for Exception Based on Medical Exemption

☐ The Contraindications or Precautions to COVID-19 vaccination recognized by the CDC or by the vaccines' manufacturers apply to me with respect to all available COVID-19 vaccines. For that reason, I am requesting an Exception to the COVID-19 vaccination requirement based on Medical Exemption. My request is supported by the attached certification from my health care provider. ***I understand that some local (city/county) public health departments have issued orders specifying that the certification must be signed by a physician, nurse practitioner, or other licensed medical professional practicing under the license of a physician.***

Part B: Request for Exception Based on Disability

☐ I have a Disability and am requesting an Exception to the COVID-19 vaccination requirement as a Disability accommodation. My request is supported by the attached certification from my health care provider. ***I understand that some local (city/county) public health departments have issued orders specifying that the certification must be signed by a physician, nurse practitioner, or other licensed medical professional practicing under the license of a physician.***

*** * * FORM CONTINUES ON NEXT PAGE * * ***

Please provide any additional information that you think may be helpful in processing your request. ***Again, do not identify your diagnosis, disability, or other medical information.***

____

While my request is pending, I understand that I must comply with the Non-Pharmaceutical Interventions (e.g., face coverings, regular asymptomatic testing) for unvaccinated or not fully vaccinated individuals as a condition of my Physical Presence at any University Location/Facility or Program. These required Non-Pharmaceutical Interventions are defined by my Location's public health, environmental health and safety, occupational health, or infection prevention authorities, including the Location Vaccine Authority. I also understand that I must comply with any additional Non-Pharmaceutical Interventions applicable to my circumstances or position, as required by my Location. If my request is granted, I understand that I will be required to comply with Non-Pharmaceutical Interventions specified by my Location as a condition of my Physical Presence at any University Location/Facility or Program.

I verify the truth and accuracy of the statements in this request form.

Employee/Student Signature: ______________________________ Date: __________

Date Received by University: _________ By: _________________________________