Request for Exemption from Mandatory COVID-19 Vaccination – ADA/Medical Reasons

To request an exemption under the ADA relating to your assignment to _____, which has adopted a Mandatory COVID-19 Vaccination Policy, please

1. Complete and sign Part 1 of this form;
2. Have your health care provider complete Part 2 of this form;
3. Submit the form to EPCC's _____ department.

Part 1 – To be Completed by the student	
Name:	**Date of Request:**
Assigned Facility:	**Instructor:**
	Work/Cell Phone:

Please initial next to each of the statements below:	
	I request an exemption based on a medical condition or disability. I understand and assume the risks of non-vaccination. I accept full responsibility for my health, thus removing liability from EPCC for the required vaccination.
	Should I contract COVID-19, I will immediately report it to my instructor and will comply with all isolation and quarantine procedures as recommended by the federal and state governments.
	I understand and agree to comply with and abide by all of EPCC's COVID-19 policies and procedures. I further understand and agree to comply with and abide by all of [Facility/Hospital] policies and procedures.
	I understand that a detailed review of my disability status may be required, and I agree to cooperate fully in this process.
	I understand that if an exemption is granted, it is only valid while EPCC's and/or [Facility/Hospital] COVID-19 vaccination policy stands and I may need to submit a new request for any subsequent changes. I further understand that the approval is provisional based on the current vaccination policy and is subject to change based on EPCC's and/or [Facility/Hospital] requirements moving forward.
	I authorize my licensed health care provider to provide EPCC with medical information about my disability or medical condition that prevents me from obtaining the COVID-19 vaccination.
	I certify that the information I have provided in connection with this request is accurate and complete as of the date of this submission. I understand this exemption may be revoked and I may be subject to disciplinary action, if any of the information I provided in support of this exemption is false.

Please state what specific exemption(s) you feel are needed and why. Please attach additional documentation, if necessary.
_____ _____ _____ _____ _____ _____ _____ _

Student Signature:	**Date:**

Part 2 – To be Completed by the Employee's Health Care Provider

Please certify below the medical reason that your patient should not be vaccinated for COVID-19 by completing this form and attaching available supporting documentation. Information provided on this form will be reviewed in consideration of the exemption request. *Please note that according to a Joint Statement from the American Board of Family Medicine, providing misinformation about the COVID-19 vaccine contradicts physicians' ethical and professional responsibilities, and therefore, may subject a physician to disciplinary actions, including suspension or revocation of their medical license.*[1]

Patient Name:	**Date:**
Health Care Provider Name:	**Health Care Provider Specialty:**
Provider License Number:	**Name of Provider Company:**
Address:	**Email:**
Phone Number:	

Option 1 – Physical Condition/ Medical Circumstance

☐ The physical condition of the patient or medical circumstances relating to the individual are such that vaccination is not considered safe. Please state, with sufficient detail for independent medical review, the specific nature and probable duration of the medical condition or circumstances that contraindicate vaccination with the COVID-19 vaccine.

Explanation:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

[1] The Joint Statement is available here: https://www.theabfm.org/about/communications/news/joint-statement-american-board-family-medicine-american-board-internal Joint Statement from the American Board of Family Medicine, American Board of Internal Medicine, and American Board of Pediatrics on Dissemination of Misinformation by Board Certified Physicians about COVID-19 | ABFM | American Board of Family Medicine (theabfm.org).

Option 2 – Other

- ☐ Other. Please provide this information in a separate narrative that describes, in detail, the medical condition or disability in detail that you opine would require this individual to need an exemption from vaccination.

Explanation:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

The condition described above is:	**If temporary, when will it end or expire:**
☐ Temporary ☐ Permanent	
Please describe any exemption or accommodation that would enable the individual to fulfill the essential functions of his or her position (e.g., any reasonable alternatives to the mandatory vaccination requirement that would enable the individual to do his/her job while effectively reducing infection and serious disease to the same extent as being fully vaccinated for COVID-19)	
_____ _____ _____	
Certification	
By signing below, I certify that the above information to be true, accurate, and complete. I further certify that the patient has the above contraindication and support the request for a medical exemption from a COVID-19 vaccine requirement.	
Medical Provider Signature:	**Date:**

Part 3 – For EPCC Purposes Only	
Date of Initial Request:	**Date Any Additional Documentation Received:**
Exemption Request:	**Date Approved/ Denied:**
□ Approved □ Denied	
If approved, describe specific exemption details:	
_____ _____ _____	
If denied, describe why exemption is denied:	
_____ _____ _____	
Date student was informed of approval/denial:	