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 (IF APPLICABLE)	SUPERVISOR (IF APPLICABLE)
PHONE NUMBER	EMAIL

This form should be used by University employees and students to request a Medical Exemption and/or Disability Exception to the COVID-19 Primary Series vaccination requirement in the University's ***SARS-CoV-2 (COVID-19) Vaccination Program***. This form should also be used by health care workers subject to the California Department of Public Health's Health Care Worker Vaccine Requirement ("CDPH order") to request a Medical Exemption to the CDPH order's booster requirement. Those who are permitted by University policy and applicable public health directives to decline COVID-19 boosters should instead use the Vaccine Declination Statement – Declination of COVID-10 Booster form.

Fill out Part A to request a Medical Exemption due to Contraindication or Precaution. Fill out Part B to request an Exception based on Disability. More than one section may be completed if applicable. Do not identify any diagnosis, disability, or other medical information. That information is not required to process your request.

Your request must be supported by a health care provider's certification. 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 A: Request for Medical Exemption Due to Contraindication or Precaution

☐ I am requesting an Exception to the COVID-19 Primary Series vaccination requirement based on Medical Exemption. The Contraindications or Precautions to COVID-19 vaccination (recognized by the U.S. Centers for Disease Control and Prevention, the California Department of Public Health, or in the case of internationally administered vaccines, the World Health Organization) apply to me with respect to all available COVID-19 Vaccines.

☐ I am a health care worker subject to the CDPH order, and I am requesting an Exception to the COVID-19 booster vaccination requirement based on Medical Exemption. The Contraindications or Precautions to COVID-19 vaccination (recognized by the U.S. Centers for Disease Control and Prevention, the California Department of Public Health, or in the case of internationally administered vaccines, the World Health Organization) apply to me with respect to all available COVID-19 boosters.

My request is supported by the attached certification from my health care provider. For health care workers subject to the CDPH order, 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 Primary Series vaccination requirement as a Disability accommodation. Health care

workers subject to the CDPH order are not eligible for this Exception. My request is supported by the attached certification from my health care provider.

Please provide any additional information that you think may be helpful in processing your request. ***Do <u>not</u> identify your diagnosis, disability, or other medical information.***

While my request is pending and if it is approved, I understand that I must comply with the Location's Non-Pharmaceutical Intervention requirements (e.g., face coverings, regular asymptomatic testing) for individuals who are not Up-To-Date on COVID-19 vaccination as a condition of my Physical Presence at any University Location/Facility or Program. I also understand that I must comply with any additional Non-Pharmaceutical Interventions applicable to my position, as required by my Location. I verify the truth and accuracy of the statements in this request form.

Employee/Student Signature: _____ Date: _____

Date Received by University: _____ By: _____

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CERTIFICATION FROM HEALTH CARE PROVIDER

Your patient is a University of California employee and/or student who has requested an Exception to the University's COVID-19 vaccination requirement based on (a) Medical Exemption due to a Contraindication or Precaution; and/or (b) Disability. Your patient is seeking to support their request for such an Exception with a certification from their qualified licensed health care provider.

HEALTH CARE PROVIDER NAME	LICENSE TYPE, # AND ISSUING STATE
FULL NAME OF PATIENT	DATE OF BIRTH OF PATIENT
PATIENT'S EMPLOYEE/STUDENT ID NUMBER	HEALTH CARE PROVIDER PHONE/EMAIL
PHYSICIAN SUPERVISOR AND LICENSE # (FOR A PHYSICIAN ASSISTANT WORKING UNDER A PHYSICIAN'S LICENSE)	

Please note the following from the Genetic Information Nondiscrimination Act of 2008 (GINA), which applies to all University employees:

> *The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.*

Please complete Part A of this form if one or more of the Contraindications or Precautions to COVID-19 vaccination recognized by the U.S. Centers for Disease Control and Prevention (CDC), the California Department of Public Health (CDPH), or in the case of internationally administered vaccines, the World Health Organization (WHO), apply to this patient. Please complete Part B if this patient has a Disability, as defined below, that makes COVID-19 vaccination inadvisable in your professional opinion. More than one section may be completed if applicable to this patient.

Important: Do not identify the patient's diagnosis, disability, or other medical information as this document will be returned to the University.

Part A: Contraindication or Precaution to COVID-19 Vaccination

☐ Primary Series. I certify that one or more of the Contraindications or Precautions (recognized by the CDC, the CDPH, or in the case of internationally administered vaccines, the WHO) for each of the currently available Vaccines used for the COVID-19 Primary Series applies to the patient listed above. For that reason, COVID-19 Primary Series vaccination using ***any*** of the currently available COVID-19 Vaccines is inadvisable for this

patient in my professional opinion. The Contraindication(s) and/or Precaution(s) is/are: ☐ Permanent ☐ Temporary.

If temporary, the expected end date is: _____.

☐ Booster. I certify that one or more of the Contraindications or Precautions (recognized by the CDC, the CDPH, or in the case of internationally administered vaccines, the WHO) for each of the currently available Vaccines used for COVID-19 boosters applies to the patient listed above. For that reason, COVID-19 booster vaccination using ***any*** of the currently available COVID-19 Vaccines is inadvisable for this patient in my professional opinion. The Contraindication(s) and/or Precaution(s) is/are: ☐ Permanent ☐ Temporary.

If temporary, the expected end date is: _____.

Part B: Disability That Makes COVID-19 Primary Series Vaccination Inadvisable

"Disability" is defined as a physical or mental disorder or condition that limits a major life activity and any other condition recognized as a disability under applicable law. "Disability" includes pregnancy, childbirth, or a related medical condition where reasonable accommodation is medically advisable.

☐ I certify that the patient listed above has a Disability, as defined above, that makes COVID-19 Primary Series vaccination inadvisable in my professional opinion. The patient's disability is: ☐ Permanent ☐ Temporary.

If temporary, the expected end date is: _____.

_____ _____

Signature of Health Care Provider Date