**University of Oregon**

**Medical Exemption Request Form for COVID-19 Booster**

**Instructions:** If you are requesting an exception from the COVID-19 vaccination booster requirement for medical reasons **AND** you do not already have an approved exemption request for the COVID-19 vaccination requirement, you must fill out this form and submit it.

# Please check the boxes below as appropriate and complete the related questions:

I am requesting an exemption from the COVID-19 vaccination booster requirement on the basis of a diagnosed physical or mental condition that limits my ability to receive the COVID-19 vaccination booster, as certified by my medical provider below.

First and Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please note that if your exception request is approved, you may be required to take additional steps to protect you and others from contracting and spreading COVID-19. Workplaces are not required to provide this exception accommodation if doing so would pose a direct threat to the excepted individual or others in the workplace or would create an undue hardship.

# Statement from Medical Provider

Your patient, named above, has requested an exemption to the COVID-19 vaccination booster requirement due to a medical condition. Please provide the information below.

# Please check an option below and complete related questions:

 The patient should not receive the COVID-19 vaccination booster due to a medical condition.

What is the medical condition that prevents them from receiving the COVID-19 vaccination booster? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

 Yes No Is the medical condition permanent?

 Yes No Is the medical condition temporary? Is yes, what is the expected

 duration? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe how this medical condition impacts their ability to receive the COVID-19 vaccination booster.

The patient may not receive a certain type of COVID-19 vaccination booster. The patient may receive a vaccination booster manufactured by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

 The patient may receive a COVID-19 vaccination booster.

I certify the above information to be true and accurate.

Printed name of medical provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work address: ­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work telephone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of medical provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_