**University of Oregon**

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

**Instructions:** Please refer to the Oregon Health Authority’s [Instructions for filling out the COVID-19 Medical Exception Request Form](https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/le3871a.pdf). If you are requesting an exception from the COVID-19 vaccination requirement for medical reasons 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 requirement on the basis of a diagnosed physical or mental condition that limits my ability to receive the COVID-19 vaccination, 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 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 due to a medical condition.

What is the medical condition that prevents them from receiving the COVID-19 vaccination?

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.

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

The patient may receive a COVID-19 vaccination.

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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

As of October 5, 2021, the content of this form is derived from the Oregon Health Authority form, available at <https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/le3870.docx>.