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 * * ***

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Please provide any additional information that you think may be helpful in processing your request. ***Again, do <u>not</u> 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: _____

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CERTIFICATION FROM HEALTH CARE PROVIDER

The University of California requires that its employees and students be vaccinated against COVID-19 infection as a condition of accessing any University location, facility, or program in person. The University may grant Exceptions to this requirement 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 vaccine's manufacturer or (b) Disability, provided that the individual's request for such an Exception is supported by 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/TRAINEE 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 CDC or the vaccines' manufacturers 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. Both sections may be completed if both apply 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.

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Part A: Contraindication or Precaution to COVID-19 Vaccination

☐ I certify that one or more of the Contraindications or Precautions recognized by the CDC or by the vaccines' manufacturers for each of the currently available COVID-19 vaccines applies to the patient listed above. For that reason, COVID-19 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 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 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