THE UNIVERSITY OF ALABAMA IN HUNTSVILLE
REQUEST FOR MEDICAL/DISABILITY EXEMPTION
2021 COVID-19 VACCINE

Employees are strongly encouraged to submit exemption requests by November 19, 2021. *You will be notified by email as to whether or not your exemption application has been approved.*

A licensed physician, physician assistant, or nurse practitioner must complete the medical exemption statement and provide his/her information below. Forms completed by the employee only will not be accepted. **Email this completed form to hr@uah.edu**. Information will be kept confidential.

EMPLOYEE SECTION – COMPLETE THE FOLLOWING INFORMATION (PRINT)

Name (last, first)_____A # _____

Department_____Job Title_____

Campus Email Address_____ Best Phone Number_____

Immediate Supervisor's Name_____

Supervisor's Email Address:_____ Phone: _____

I am seeking the following type of medical/disability exemption:

Option 1 – Allergy/Contraindication

□ A documented history of a severe allergic reaction to any component of a COVID-19 vaccine, to a substance that is cross-reactive with a component, or to a previous dose of the COVID-19 vaccine or other contraindication to the COVID-19 vaccine, such as treatment with Monoclonal Antibodies for COVID-19 within 90 days.

Option 2 – Physical or Mental Impairment/Other Medical Circumstance

□ A physical or mental impairment that substantially limits one or more major life activities or other medical condition and that makes taking the COVID-19 vaccination medically unsafe. Please describe below.

I verify that the above information is complete and accurate to the best of my knowledge, and I understand that any intentional misrepresentation contained in this request may result in disciplinary action, up to and including termination of my employment. I also understand that my request for an exemption may not be granted if it is not reasonable or if it creates an undue hardship on my employer.

I give consent for an authorized representative of Human Resources to contact the provider completing this form if additional information or medical records are required. I understand that should my exemption application be approved, UAH may institute additional safety measures to limit the spread of COVID-19. Such safety measures may include regular or random COVID testing, usage of enhanced PPE, or other measures as determined necessary to provide for the safety of the work environment.

Signature:_____ Date:_____

Print Name:_____

PROVIDER SECTION – COMPLETE THE FOLLOWING INFORMATION

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.

OPTION 1 – ALLERGY/CONTRAINDICATION

Physician/Provider Instructions: Completing this form verifies that different methods of vaccinating against COVID-19 have been considered, and that the following medical contraindication precludes vaccination for COVID-19.

CDC considers a history of the following to be a contraindication to vaccination with COVID-19 vaccines:

- Severe allergic reaction (e.g., anaphylaxis) after a previous dose of COVID-19 vaccine or to a component of the COVID-19 vaccine.
- Immediate allergic reaction of any severity to a previous dose of COVID-19 vaccine or known (diagnosed) allergy to a component of the vaccine. An immediate allergic reaction is defined as any hypersensitivity-related signs or symptoms consistent with urticaria, angioedema, respiratory distress (e.g., wheezing, stridor) or anaphylaxis that occur within four hours following administration of medication.
- A person who has a contraindication to an mRNA vaccine because of an allergy to a component of the vaccine has a precaution for receiving the Johnson & Johnson vaccine but may be eligible to receive the Johnson & Johnson vaccine after consultation with an allergist or immunologist to determine eligibility. Similarly, a person who has a contraindication to the Johnson & Johnson vaccine because of an allergy to a component of the vaccine has a precaution for receiving an mRNA vaccine but may be eligible to receive one of the mRNA vaccines (Moderna or Pfizer) after consultation with allergist or immunologist.

The following is a TEMPORARY contraindication to vaccination with COVID-19 vaccine:

- Treatment with Monoclonal Antibodies for COVID-19 within 90 days. Individuals may receive COVID-19 vaccine 90 days after treatment with Monoclonal Antibodies for COVID-19.

The following are NOT CONSIDERED contraindications to COVID-19 vaccination:

- Minor acute illness (e.g., diarrhea and minor upper respiratory tract illnesses, including otitis media)
- Mild to moderate local reactions and/or low-grade moderate fever following a prior dose of the vaccine
- Sensitivity to a vaccine component (e.g., upset stomach, soreness, redness, itching, swelling at the injection site)
- Current antimicrobial therapy
- Disease exposure or convalescence
- Pregnant or breastfeeding
- Pregnant or immunosuppressed person in the household

Document the patient's contraindication to receiving the COVID-19 vaccine. If more space is needed, attach additional sheets to this form. Medical record documentation must be attached to this form before submitting for review.

□ Severe allergic reaction (e.g., anaphylaxis) after a previous dose of COVID-19 vaccine or to a component of the COVID-19 vaccine.

□ Immediate allergic reaction of any severity to a previous dose of COVID-19 vaccine or known (diagnosed) allergy to a component of the vaccine. An immediate allergic reaction is defined as any hypersensitivity-related signs or symptoms consistent with urticaria, angioedema, respiratory distress (e.g., wheezing, stridor) or anaphylaxis that occur within four hours following administration of medication.

□ Treatment with Monoclonal Antibodies for COVID-19 within 90 days. Individuals may receive COVID-19 vaccine 90 days after treatment with Monoclonal Antibodies for COVID-19.

Please provide date and detailed description of reaction checked above with supporting documentation:

OPTION 2 – PHYSICAL OR MENTAL IMPAIRMENT / OTHER MEDICAL CONDITION

□ **The physical condition of the patient or medical circumstances relating to the individual are such that vaccination is not considered safe.**

Physician/Provider Instructions: Please provide below, with sufficient detail for independent medical review, the following information:

- The specific nature of the physical or mental impairment or medical condition.
- The probable duration of the physical or mental impairment or medical condition.
- An explanation of the medical reasons the patient's physical or mental impairment or medical condition contraindicates vaccination with the COVID-19 vaccine.
- Please attach additional pages and/or records as necessary.

Signature of Health Care Provider:_____ **Date:**_____

Printed Name:_____

Practice Name:_____

Practice Telephone Number:_____

Practice Email Address: _____

State of Alabama COVID-19 Vaccination Exemption Form

A#:_____Date of Request:_____

Name:_____

Job Title:_____

Department:_____

Campus email address:_____Campus phone number:_____

Immediate Supervisor:_____

Supervisor’s email address:_____Phone:_____

Any individual in the State of Alabama who is subject to a requirement that he or she receive one or more COVID-19 vaccinations as a condition of employment may claim an exemption for medical reasons, because the vaccination conflicts with sincerely held religious beliefs, or both.

You may request either a medical or a religious exemption from the COVID-19 vaccination by completing this form and submitting the form to your employer.

In the event your employer denies this request, you have a right to file an appeal with the Department of Labor within 7 days. Your employer will provide you with information on how to file an appeal.

I am requesting exemption from the COVID-19 vaccine requirements for one of the following reasons: (check all that apply)

☐ My health care provider has recommended to me that I refuse the COVID-19 vaccination based on my current health conditions and medications. (NOTE: You must include a licensed health care provider's signature on this form to claim this exemption.)

☐ I have previously suffered a severe allergic reaction (e.g., anaphylaxis) related to vaccinations in the past.

☐ I have previously suffered a severe allergic reaction related to receiving polyethylene glycol or products containing polyethylene glycol.

☐ I have previously suffered a severe allergic reaction related to receiving polysorbate or products containing polysorbate.

☐ I have received monoclonal antibodies or convalescent plasma as part of a COVID-19 treatment in the past 90 days.

____ I have a bleeding disorder or am taking a blood thinner.

____ I am severely immunocompromised such that receiving the COVID-19 vaccination creates a risk to my health.

____ I have been diagnosed with COVID-19 in the past 12 months.

____ Receiving the COVID-19 vaccination conflicts with my sincerely held religious beliefs, practices, or observances.

I hereby swear or affirm that the information in this request is true and accurate. I understand that providing false or misleading information is grounds for discipline, up to and including termination from employment.

_____
Employee's Printed Name

_____
Employee's Signature

_____
Date

(Note: The following must be completed ONLY if claiming the first medical exemption listed above.)

Certification by a licensed health care provider as to the accuracy of information provided above:

_____
Name of Health Care Provider

_____
Signature of Health Care Provider

_____
Date