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**REQUEST FOR MEDICAL EXEMPTION FROM COVID-19 VACCINATION**

**If you have an allergy to the COVID-19 vaccine or a specific medical condition that precludes the COVID-19 vaccination requirement and you seek a medical exemption from UMES’s COVID-19 vaccination requirement, please consult with your physician and provide the following information.**

**Please print the following information:**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone No.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Supervisor** (employees)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Department/School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician Phone No.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physician Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Dear Physician:**

**The University of Maryland Eastern Shore, as mandated by the University System of Maryland, requires COVID-19 vaccinations for all students, faculty and staff. A medical exemption from COVID-19 vaccination is allowed for certain recognized contraindications (**[**https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html**](https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html)**).**

**Please complete the form below. Should you have any questions, please contact** humanresources@umes.edu  **or call (410) 651-6400. Thank you.**

**The above person should not be immunized for COVID-19 for the following reasons (Please check all that apply):**

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

 **Immediate allergic reaction of any severity to a previous dose or known (diagnosed) allergy to a component of the vaccine (Vaccine Ingredients:** [**https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html#Appendix-C**](https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html#Appendix-C)**)**

 **Which ingredient caused an allergic reaction? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **What was the reaction? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Which brand of the COVID-19 vaccine is contraindicated and why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How long will the medical contraindication last? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Other Medical Reason – Please provide this information in a separate narrative that describes the other medical reason justifying an exemption in detail.**

**FOR THE PHYSICIAN**

**I certify that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ has the above contraindication or specific medical condition and request a medical exemption from COVID-19 vaccination.**

**Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

(Note: Signature Stamp Not Acceptable)

**Physician Medical License No.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPI No.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**FOR THE REQUESTOR (Student/Faculty/Staff)**

**Verification and Accuracy:**

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 which may include termination/dismissal (faculty/staff) and suspension/expulsion (students). I also understand that my request for an exemption may not be granted if it creates an undue hardship for the University.

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Hawk ID No. (students only):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Parent or Guardian (if <18 years old) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Confidentiality of Information Provided**

Requests for exemptions and any documents provided will be kept confidential and shared only with those university employees who have a need to know.

**PLEASE E-MAIL this completed form to: humanresources@umes.edu**

**Summary of Next Steps:**

1. Receipt of this medical exemption request will be acknowledged by the University Health Center (students) and/or the Office of Human Resources (faculty and staff).
2. You will be notified of the decision regarding your requested medical exemption.
3. If you are granted a medical exemption, you will be required to undergo COVID-19 testing in addition to observing all COVID-19 health and safety protocols.
4. The University will reconsider a denial only if you bring forth new information supporting your request. For reconsideration of a denial, please contact the Office of Human Resources (for

faculty/staff) and the Office of Student Affairs (for students).

**DESIGNATED OFFICE USE ONLY:**

Medical Exemption Approved Date: \_\_\_\_\_\_\_\_\_\_\_ Approving Staff Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name/ Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_