Western University
OF HEALTH SCIENCES

POST COVID-19 INFECTION BOOSTER DEFERRAL REQUEST

Name:_____ DOB: _____

College/Department: _____ WesternU ID#: @_____

WesternU Mandatory COVID-19 Vaccine Policy

WesternU requires all faculty, staff, trainees, residents, and students to be fully vaccinated and up to date on their COVID-19 vaccine. Individuals who provide proof of a recent COVID-19 infection after completion of their primary COVID-19 vaccine series, can request a deferral of the COVID-19 booster up to 90 days from date of the first positive test or clinical diagnosis.

In order to qualify this deferral please indicate your initial date of positive test or clinical diagnosis: _____

To provide proof of prior infection, individuals must provide documentation of previous diagnosis from a licensed healthcare provider, confirmed laboratory results, or university contact tracing report.

If approved, this deferral is valid for 90 days after your initial date of positive test or clinical diagnosis. Individuals with a deferral due to a proven COVID-19 infection must be in compliance no later than 15 days after the expiration of their deferral.

Individual Certification: By signing this Post COVID-19 Infection Booster Deferral, I attest that I am requesting a deferral to receive a COVID-19 booster because I was recently proven to be infected with COVID-19. 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. I consent to allow WesternU representatives to contact my health care professional(s) regarding my condition, **only as it relates to my ability to receive the vaccine booster**. I understand that WesternU reserves the right to deny my Post COVID-19 Infection Booster Deferral Request should it determine that based on the information provided or received, adequate evidence has not been provided to establish that a deferral is warranted. I acknowledge that declining the COVID-19 vaccination could result in additional safety precautions while on-campus, including but not limited to the use of personal protection equipment and testing.

Signature:_____ Date: _____

For use by WesternU Student-Employee Health Office (SEHO) only:

Date Received: _____ _____

Received by (staff name) : _____ Signature:_____

Approved: ☐ Yes ☐ No

Date Approved/Denied:_____

Date Deferral Expires:_____

Approval/Denial By (Print Name):

Please send a copy of this form, to stu-emphealth@westernu.edu and on the subject line enter "COVID vaccine"