MEDICAL OR DISABILITY EXEMPTION REQUEST

Western University OF HEALTH SCIENCES

Name:_____ DOB: _____

College/Department: _____ WesternU ID#: @_____

WesternU Mandatory COVID-19 Vaccine Policy

WesternU requires all faculty, staff, trainees, residents, and students who are Working and Learning on-site at the University or affiliated facilities to be fully vaccinated against COVID-19 vaccine. Individuals can request exemption if they cannot receive the COVID-19 vaccine due to a medical contradiction or a medical condition or disability.

In order to qualify for a medical or disability exemption, please complete the header above, sign and date the "Individual Certification" section and submit the document to your Authorized Health Care Provider for execution.

Individual Certification: I have provided this certification to my licensed health care provider to certify that I am unable to receive the COVID-19 vaccine due to medical contraindication and/or due to my medical condition or disability. I understand that any intentional misrepresentation contained in this request may result in disciplinary action. I consent to allow WesternU representatives to consult with my health care professional(s), **only as it relates to my ability to receive the above vaccine**. I understand that WesternU reserves the right to deny my Medical or Disability Exemption Request should it determine that based on the information provided or received, adequate evidence has not been provided to establish that an exemption is warranted. I acknowledge that declining the COVID-19 vaccination could result in additional safety precautions while on-campus, including but not limited to personal protection equipment and testing.

Vaccines and Clinical Rotations: WesternU's clinical affiliates reserve the right to deny an unvaccinated student access to their facilities for the purposes of meeting the requirements of our curriculum. Should this occur, the student is advised to reach out to their college's rotations coordinator for assistance in locating another site, if available. Therefore, please be aware that a student's vaccination status may prevent students from entering hospital facilities or clinical sites, which may directly hinder a student's ability to complete their academic program successfully and/or on time.

Signature:_____ Date: _____

MUST COMPLETE BOTH PAGES

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

Authorized Health Care Provider (HCP) Certification Section

_____ [Name of licensed MD, DO, PA, NP] certify that the above-named individual is under my medical care and has a medical condition or disability that contraindicates their vaccination with the COVID-19 Vaccine at this time. This contraindication is based on (choose one):

☐ The applicable CDC contradiction and/or FDA contraindication(s) to this vaccine
(If checked) : **This contraindication is** ☐ **Permanent or** ☐ **Temporary**
If temporary please indicate expiration date of the medical exemption: _____

☐ The physical or medical condition of the person, a disability, or medical circumstances relating to the person are such that the COVID-19 immunization is harmful to the health and well-being of the person named above.

Health Care Provider's License #:_____

Address:_____

Telephone Number: _____

Practitioner Stamp (if available): _____

Signature of Authorized HCP:_____ Date: _____

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

Date Received: _____
Received by (staff name) : _____
Approved: ☐ Yes ☐ No
Date Approved:_____
Date Denied:_____

Approval/Denial By (Print Name):
_____

Signature:_____

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