

**REQUEST FOR MEDICAL/DISABILITY EXEMPTION
2021 COVID-19 VACCINE**

This application must be completed and submitted no later than November 19, 2021. You will be notified via portal message as to whether or not your exemption application has been approved. If you do not have an active portal/ email account, you will be contacted at the phone number you provide below.

In addition to this exemption application, which must be completed, the Alabama COVID-19 Exemption Form is attached and available to you for completion. The Alabama COVID-19 Exemption Form is optional. If you choose to complete this additional form, it will be reviewed and evaluated as part of your exemption request.

NOTE: You must submit an exemption request for the COVID-19 vaccine even if you have submitted exemption requests for other vaccination requirements in the past.

If you have a disability and need assistance completing this form, please contact Disability Support Services at dss@uab.edu or 205-934-4205 (voice) or (205) 934-4205 (TDD).

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. **Please upload this completed form to the Student Health patient portal at https://studentwellness.uab.edu/login_directory.aspx** . Information will be kept confidential.

TRAINEE SECTION – COMPLETE THE FOLLOWING INFORMATION (PRINT)

Name (last, first) _____

Best Phone Number _____

Email Address _____

Will you be providing direct patient care as part of your participation in a third-party placement?
 Yes No

Will you be working in an area where patient care is provided (e.g., unit or clinic) as part of your participation in a third-party placement?
 Yes No

Will you have contact with patients/visitors (e.g., registering, providing directions, taking payments) or healthcare workers as part of your participation in a third-party placement?
 Yes No

Will you be providing services to patients/visitors (e.g., food preparation, financial counseling, music therapy) as part of your participation in a third-party placement?

- Yes No

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

Option 1 – Allergy

- 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.

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.

Describe: _____

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 third-party placement. 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.

I understand that my exemption only applies to my enrollment at UAB and it may also need to be approved by my third-party placement site/agency. I further understand my third-party placement/site 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 a safe environment.

I give consent for Student Health Services or its physicians to contact the provider completing this form if additional information or medical records are required. I understand that UAB Student Health Services will only share acquired vaccination records or information and/or my exemption status to comply with the law or with third-party agreements. I also understand that my progression in my program or field of study may be delayed if I do not comply with third-party immunization requirements or do not have an exemption.

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

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. Guidance for medical exemptions for COVID-19 vaccination can be obtained from the most recent recommendations of the Advisory Committee on Immunization Practices (ACIP), available in the Centers for Disease Control and Prevention publication: <https://www.cdc.gov/coronavirus/2019-ncov/downloads/communication/Guidance-Review.pdf> and from the Interim Clinical Considerations for Use of COVID-19 Vaccines Currently Authorized in the United States.: https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fvaccines%2Fcovid-19%2Finfo-by-product%2Fclinical-considerations.html.

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:

Describe: _____

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.

Describe: _____

Signature of Health Care Provider: _____

Date: _____

Printed Name: _____

Practice Name: _____

Practice Telephone Number: _____

ALABAMA COVID-19 EXEMPTION FORM

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.

[Redacted]

[Redacted]

Employee's Printed Name

[Redacted]

[Redacted]

Employee's Signature

[Redacted]

[Redacted]

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:

[Redacted]

[Redacted]

Name of Health Care Provider

[Redacted]

[Redacted]

Signature of Health Care Provider

[Redacted]

Date