Heidelberg
UNIVERSITY

Human Resources

MEDICAL EXEMPTION - Vaccination Requirement

EMPLOYEE VACCINATION MEDICAL EXEMPTION FORM - DUE BY JANUARY 3, 2022

Employees may request a medical exemption from the COVID-19 Vaccination Requirement for medical reasons.

Instructions: To request a medical exemption, please fill out and sign the form. Your licensed medical provider is to complete the Medical Documentation of Licensed Medical Provider section. Once completed, please do one of the following:

- **Drop Off** the completed form to the HR Office, University Hall, C210 **OR**
- **Mail** the completed form to Heidelberg University, attn: HR, 310 E. Market St., Tiffin, OH 44883

The exemption request will be reviewed on a case-by-case basis by Human Resources. Human Resources will interact with the employee about the request, as needed.

The University reserves the right to request additional supporting documentation regarding the request, or to not review request forms that are incomplete.

Last Name____________________________________ First Name____________________________

Department____________________________ Email___________________ Phone _______________

The above-named employee requests a medical exemption from the HU COVID-19 Vaccination Requirement.

A medical exemption is allowed for certain medical conditions and contraindications to receiving the COVID-19 vaccine, as identified by the employee and as documented by a licensed medical provider.

1. Identify the mental or physical impairment or other medical condition that interferes with or may interfere with your ability to receive a COVID-19 vaccination or other vaccine:

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2. If HU provides you with a medical exemption from the COVID-19 Vaccination Requirement, HU may consider and require additional health and safety procedures, including mask obligations, physical distancing, and testing requirements. I acknowledge that if my request for an exemption is granted, I will need to comply with such additional safety procedures as instructed by HU.

3. I verify that the information I am submitting to substantiate my request for a medical exemption from HU's Vaccination Requirement is true and accurate to the best of my knowledge.

The above-named employee understands that by submitting the Heidelberg University medical exemption form for the COVID-19 Vaccination Requirement and if the exemption is granted, the employee assumes the risk of not receiving the vaccination, including but not limited to illness, health effects, or other consequences related to the imposition of health and safety protocols.

Signature:____ Date: __________________

Medical Documentation of Licensed Medical Provider:

TO BE COMPLETED BY MEDICAL PROVIDER:

Provider Name: ____

Provider Address: ____

Provider Phone & Email Address: ____

Patient Name: ____

I am a licensed medical provider who is familiar with the medical status of the above-named individual. In my medical opinion, the above-named individual should not be immunized with the COVID-19 vaccination(s) for the following reasons:

□ History of previous allergic reaction or hypersensitivity reaction to the COVID vaccine or a component of the vaccine.

□ Prior diagnosis and/or positive test for infection with COVID-19 within the last 90 days. Please provide documentation of diagnosis and/or positive test, including date of test and/or diagnosis. Person is only eligible for a temporary exemption until after the end of the 90-day period after which the person will be required to receive a COVID-19 vaccination.

□ Other – Please provide documentation/information that describes the medical condition(s) or medical reasons that prevent the above-named individual from receiving vaccination for COVID.

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Period For Which Vaccination Medical Exemption Is Required

The request for a medical exemption from the above-listed vaccination requirement is:

☐ Temporary, expiring on:______/____/_______.

☐ Permanent.

I certify that the above-named individual has the listed medical conditions and/or contraindications and confirm the accuracy of the information submitted. I support the need for a medical exemption from the COVID-19 vaccination.

Licensed Medical Provider Signature: ________________________________Date: ______________

Licensed Medical Provider Medical License No.: ____

Stamp of Licensed Medical Provider:

For HR Use:

Date Form Received: ________________ Approved ____ Not Approved ___

Date Form Returned to Employee: ________________