

UNIVERSITY OF CALIFORNIA
MEDICAL EXEMPTION AND/OR DISABILITY EXCEPTION REQUEST FORM
Exception to SARS-CoV-2 (COVID-19) Vaccination Requirement

EMPLOYEE OR STUDENT NAME	EMPLOYEE OR STUDENT ID
JOB TITLE (IF APPLICABLE)	LOCATION
DEPARTMENT	SUPERVISOR (IF APPLICABLE)
PHONE NUMBER	EMAIL

This form should be used by University employees and students to request an Exception to the COVID-19 vaccination requirement in the University's [SARS-CoV-2 Vaccination Program Policy](#) based on (a) Medical Exemption due to a Contraindication or Precaution to COVID-19 vaccination [recognized by the U.S. Centers for Disease Control and Prevention \(CDC\)](#) or by the vaccines' manufacturers; (b) Medical Exemption due to COVID-19 diagnosis or treatment within the last 90 days; or (c) Disability.

Fill out Part A to request a Medical Exemption due to Contraindication or Precaution. Fill out Part B to request a Medical Exemption due to COVID-19 diagnosis or treatment within the last 90 days. Fill out Part C to request an Exception based on Disability. More than one section may be completed if applicable. Important: Do not identify any diagnosis, disability, or other medical information (other than COVID-19 diagnosis in Part B). That information is not required to process your request.

Part A: Request for Medical Exemption Due to Contraindication or Precaution

- The Contraindications or Precautions to COVID-19 vaccination recognized by the CDC or by the vaccines' manufacturers apply to me with respect to all available COVID-19 vaccines. For that reason, I am requesting an Exception to the COVID-19 vaccination requirement based on Medical Exemption. My request is supported by the attached certification from my health care provider. ***I understand that some local (city/county) public health departments have issued orders specifying that the certification must be signed by a physician, nurse practitioner, or other licensed medical professional practicing under the license of a physician.***

Part B: Request for Medical Exemption Due to COVID-19 Diagnosis or Treatment

- I have been diagnosed with or treated for COVID-19 within the last 90 days. For that reason, I am requesting an Exception to the COVID-19 vaccination requirement based on Medical Exemption. My request is supported by the attached certification from my health care provider. ***I understand that some local (city/county) public health departments have issued orders specifying that the certification must be signed by a physician, nurse practitioner, or other licensed medical professional practicing under the license of a physician.***

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Part C: Request for Exception Based on Disability

- I have a Disability and am requesting an Exception to the COVID-19 vaccination requirement as a Disability accommodation. My request is supported by the attached certification from my health care provider. ***I understand that some local (city/county) public health departments have issued orders specifying that the certification must be signed by a physician, nurse practitioner, or other licensed medical professional practicing under the license of a physician.***

Please provide any additional information that you think may be helpful in processing your request. ***Again, do not identify your diagnosis, disability, or other medical information.***

While my request is pending, I understand that I must comply with the Non-Pharmaceutical Interventions (e.g., face coverings, regular asymptomatic testing) for unvaccinated or not fully vaccinated individuals as a condition of my Physical Presence at any University Location/Facility or Program. These required Non-Pharmaceutical Interventions are defined by my Location's public health, environmental health and safety, occupational health, or infection prevention authorities, including the Location Vaccine Authority. I also understand that I must comply with any additional Non-Pharmaceutical Interventions applicable to my circumstances or position, as required by my Location. If my request is granted, I understand that I will be required to comply with Non-Pharmaceutical Interventions specified by my Location as a condition of my Physical Presence at any University Location/Facility or Program.

I verify the truth and accuracy of the statements in this request form.

Employee/Student Signature: _____ Date: _____

Date Received by University: _____ By: _____