

University of Illinois Springfield

REQUEST FOR MEDICAL EXEMPTION FROM COVID-19 VACCINATION

The University of Illinois Springfield is committed to building an inclusive and welcoming campus environment.

If you have an allergy to the COVID-19 vaccine or a specific medical condition that precludes the COVID-19 vaccination requirement and you seek a medical exemption from the UIS COVID-19 vaccination requirement, please consult with your physician and provide the following information.

Please print the following information:

Name: _____ **Job Title:** _____

Email: _____ **Phone No.:** _____

Physician Name: _____ **Physician Phone No.:** _____

Physician Address: _____

Dear Physician:

UIS requires COVID-19 vaccinations for all employees. A medical exemption from COVID-19 vaccination is allowed for certain recognized contraindications (<https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html>).

Please complete the form below. Thank you.

The above person should not be immunized for COVID-19 for the following reasons (Please check all that apply):

- Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a component of the COVID-19 vaccine
- Immediate allergic reaction of any severity to a previous dose or known (diagnosed) allergy to a component of the vaccine (Vaccine Ingredients: <https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html#Appendix-C>)

Which ingredient caused an allergic reaction? _____

What was the reaction? _____

Which brand of the COVID-19 vaccine is contraindicated and why? _____

How long will the medical contraindication last? _____

- Other Medical Reason – Please provide this information in a separate narrative that describes the other medical reason justifying an exemption in detail.

FOR THE PHYSICIAN

I certify that _____ has the above contraindication or specific medical condition and request a medical exemption from COVID-19 vaccination.

Physician Signature: _____ Date: _____
(Note: Signature Stamp Not Acceptable)

Physician Medical License No.: _____ NPI No.: _____

Verification and Accuracy

FOR THE REQUESTOR (Student/Faculty/Staff)

I affirm that the above information I have provided is complete and accurate. I understand that, if granted an exemption, I must comply with all mitigation measures required of me by the University. Such measures include but are not limited to: participating in periodic COVID-testing at a frequency determined by the University, wearing face covering in settings determined by the University (i.e. classrooms, labs, etc.) and maintaining certain physical distancing as determined by the University. I understand that I may be required to curtail certain activities if the University determines that participation of unvaccinated individuals presents an unreasonable risk to the campus community. I agree that should I contract a vaccine preventable disease, I will hold the university harmless and will comply with any and all limitations placed upon me by the University of Illinois or public health officials. I understand that my request for an exemption may not be granted or may be modified or rescinded to minimize the risk to campus safety. I understand that any intentional misrepresentation contained in this request may result in disciplinary action up to and including dismissal.

Signature: _____ Date: _____

Print Name: _____ Job Title: _____

Confidentiality of Information Provided

Requests for exemptions and any documents provided will be kept confidential and shared only with those university employees who have a need to know.

Summary of Next Steps

1. This request will be reviewed and acknowledged by Human Resources. Additional information may be requested.
2. After review, you will be notified of the decision regarding your requested medical exemption.
3. If you are granted a medical exemption, you will be required to undergo COVID-19 testing in addition to observing all COVID-19 health and safety protocols and will be informed of any additional accommodations.