REQUEST FOR MEDICAL EXEMPTION/ACCOMMODATION RELATED TO COVID-19 VACCINATION PART 1

To request an Exemption/Accommodation related to the University's COVID-19 vaccination requirement, please complete Part 1 of this form, have your healthcare provider complete Part 2 (the certification portion). Medical exemptions/accommodations for the COVID-19 vaccine will be considered if employee provides a written certification by a licensed, treating medical provider [i.e. a physician (MD or DO), nurse practitioner (NP), or physician's assistant (PA)].

TO BE COMPLETED BY THE EMPLOYEE:

Employee Name: ___________________________________ U #: ___________________________

______ Initials	**Verification of Accuracy:** I verify that the information I am submitting in support of my request for an accommodation 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. I also understand that my request for an accommodation may not be granted if it is not reasonable, if it poses a direct threat to the health and/or safety of others in the workplace, school environment, housing facilities and/or to me, or if it creates an undue hardship on the University.
______ Initials	**Medical Release:** I hereby authorize my medical provider to release my medical information to Southern University at New Orleans for the purpose of engaging in the interactive process to determine the availability of reasonable accommodations in response to my vaccine exemption request.

Employee Signature: ___________________________________ Date: __________________________

REQUEST FOR MEDICAL EXEMPTION/ACCOMMODATION RELATED TO COVID-19 VACCINATION PART 2

University Name: Southern University at New Orleans

Employee Name: ______________________________ U#: ________________________

ATTN: MEDICAL PROVIDER

The University requires all employees to receive the COVID-19 vaccine by November 1, 2021. The above-named individual is requesting an exemption from this vaccination requirement. A medical exemption from the COVID-19 vaccination may be allowed for certain recognized contraindications.

Please complete the form below.

Should you have any questions, please contact Sheryl Crosby, R.N. at 504-286-5374.

Thank you.

TO BE COMPLETED BY THE EMPLOYEE'S MEDICAL PROVIDER:

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

______	History of previous allergic reaction to indicate an immediate hypersensitivity reaction to a component of the vaccine.
______	The physical condition of the person or medical circumstances relating to the person are such that immunization is not considered safe. **Please indicate the specific nature and probable duration of the medical condition or circumstances that contraindicate immunization with the COVID-19 vaccine.**
______	Other – Please provide this information in a separate narrative that describes the exemption in detail.

I, the undersigned, do hereby certify that ____________________________________ has the above
PRINT NAME OF EMPLOYEE
the above contraindication, and I request a medical exemption from the COVID-19 vaccination.

Medical Provider Signature: ______________________________ Date: __________________

Print Name: ____

Office Address: ____
Street City State Zip

Phone Number: ____