



## MEDICAL EXEMPTION / ACCOMMODATION REQUEST RELATED TO COVID-19 VACCINATION REQUIREMENT

**\*\* NOTE \*\***

In order to ensure a prompt review of your request, this form **must** be completed, accompanied by your medical provider's certification and submitted to the University's Disability Services Office (if a student) or Human Resources Department (if an employee) **at the same time**. Failure to submit this form, together with the other required documentation, may result in a delayed evaluation of your request and impede the University's ability to timely provide the requested exemption and accommodation.

Clark Atlanta University (the "University") is committed to providing equal employment and educational opportunities without regard to any protected status and a work and educational environment that is free of unlawful harassment, discrimination, and retaliation. As such, the University is committed to complying with all laws protecting individuals with disabilities or medical conditions. When requested, the University will provide an exemption/reasonable accommodation for any known medical condition or disability of a qualified individual which prevents the student or employee from receiving a COVID-19 vaccine, provided the requested accommodation is reasonable and does not create an undue hardship for the University or pose a direct threat to the health and/or safety of others in the workplace, educational environment, residence halls (if applicable) and/or to the requesting student or employee.

To request a Medical 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), and return them to Disability Services (if a student) or Human Resources (if an employee). This information will be used by Human Resources, Disability Services or other appropriate personnel to engage in an interactive process to determine eligibility for such exemption/accommodation and if applicable, to determine the reasonable accommodations which can be provided to enable the student to have an equal opportunity to participate in the education program/activity or the employee to perform the essential functions of their position without posing a threat of harm to self or others. If a student or employee refuses to provide such information, such a refusal may impact the University's ability to adequately understand the individual's request or to effectively engage in the interactive process to identify possible accommodations.

Medical exemptions/accommodations for the COVID-19 vaccine will be considered if the student or 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)] of one of the following:

1. The applicable CDC contraindication for the COVID-19 vaccine, or
2. The applicable contraindication found in the manufacturer's package insert for the COVID-19 vaccine; or
3. A statement that the physical condition of the person or medical circumstances relating to the person are such that vaccination is not considered safe, indicating the specific nature and probable duration of the medical condition or circumstances that contraindicate immunization with the COVID-19 vaccine.

**PART 1 – TO BE COMPLETED BY THE STUDENT (OR PARENT/GUARDIAN IF STUDENT IS UNDER 18 YEARS OF AGE) OR EMPLOYEE:**

Name (Student or Employee): \_\_\_\_\_ 900 #: \_\_\_\_\_ Date of Request: \_\_\_\_\_

Email Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

_____ Initials	<b>Verification of Accuracy:</b> The undersigned verifies that the information submitted in support of this request for an accommodation is complete and accurate to the best of his or her knowledge, and the undersigned understands that any intentional misrepresentation contained in this request may result in disciplinary action. The undersigned also understands that this 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 (if a student or employee), or if it creates an undue hardship on the University.
_____ Initials	<b>Medical Release:</b> The undersigned hereby authorizes my medical provider (or my student's medical provider, if the student is under the age of 18) to release my (or my student's) medical information to Clark Atlanta University for the purpose of engaging in the interactive process to determine the availability of reasonable accommodations in response to my vaccine exemption request. I understand that I may revoke this authorization in writing at any time, except to the extent that Clark Atlanta University has taken action in reliance of this authorization, and if I revoke this authorization, such revocation will not have any effect on disclosures made prior to such revocation. I have had the opportunity to read and consider the contents of this authorization. I confirm that the contents are consistent with my direction. A photocopy of this form shall have the same legal validity as the original.

Signature (Student, if 18 years of age or older, or Employee): \_\_\_\_\_

**Required if Student is Under the Age of 18:** Parent/Legal Guardian's Name (Print): \_\_\_\_\_

Parent/Legal Guardian's Signature: \_\_\_\_\_

**PART 2 – TO BE COMPLETED BY THE STUDENT OR EMPLOYEE’S MEDICAL PROVIDER**

University Name: Clark Atlanta University (the “University”)

Student or Employee Name: \_\_\_\_\_

**ATTN: Medical Provider**

The University requires all students and employees to receive the COVID-19 vaccine prior to arrival on the University’s campus for the **Spring 2022** academic semester. 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 \_\_\_\_\_ at \_\_\_\_\_.

Thank you.

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. <b>Please indicate the specific nature and probable duration of the medical condition or circumstances that contraindicate immunization with the COVID-19 vaccine.</b>
_____	Other – Please provide this information in a separate narrative that describes the exemption in detail.

I, the undersigned, do hereby certify that \_\_\_\_\_ (Print Name of Student or Employee) has the above contraindication, and I request a medical exemption from the COVID-19 vaccination.

Medical Provider Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

Office Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

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