UNIVERSITY OF THE DISTRICT OF COLUMBIA 1851

MEDICAL EXEMPTION REQUEST FORM

To request an exemption from receiving the COVID-19 vaccination, please complete Section 1 below and have your medical provider complete Section 2 before returning this form to Health Services.

PLEASE SUBMIT THIS FORM AND ATTACHED STATEMENT TO THE UNIVERSITY HEALTH SERVICES BY UPLOADING TO: www.udc.studenthealthportal.com or call UHS at 202-274-5030

Section 1

Name:_____ **Date of Birth:**_____

Email:_____ **Phone No:**_____

Department/School:_____ **Student ID N#:**_____

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

Physician Adress:_____

_____

I am requesting a medical exemption from the University's mandatory vaccination policy.

I verify that the information I am submitting to substantiate my request for exemption from the University's COVID-19 vaccination policy is true and accurate to the best of my knowledge. I understand that any falsified information can lead to disciplinary action, including suspension and expulsion.

Student's Signature:	Date:
Name (Please Print)	

All medical documentation submitted to University Health Services will remain confidential.

Section 2

Medical Certification for COVID-19 Vaccination Exemption

Student's Name: _____

Dear Medical Provider:

A mandatory COVID-19 vaccination policy is in effect at the University of the District of Columbia. The individual named above is requesting an exemption to this vaccination requirement due to medical contraindications.

Please complete this form to assist the University in the reasonable exemption process.

The person named above should not be immunized for COVID-19 for the following reasons:

☐ Severe allergic reaction ☐ Immediate allergic reaction

☐ Other_____

_____

This exemption should be:

☐ Temporary, expiring on: __/__/__, or when_____

_____

☐ Permanent

I certify the above information to be true and accurate, and request exemption from the **COVID-19** vaccination for the above-named individual.

Medical Provider Name (print):	
Medical Provide Signature:	Date:
Practice Name and Address:	Provider Phone:

HEALTH SERVICES USE ONLY

Date of initial request: __/__/__ Date received: __/__/__

Exemption request:

☐ Approved __/__/__

☐ Denied __/__/__ Date Student Notified: __/__/__

Describe why exeption is denied: _____

Approving Staff Name/Signature:_____