THE UNIVERSITY OF MEMPHIS

COVID-19 Vaccine Medical Accommodation Request Form
-Confidential-

This form relates to your request for an accommodation/exemption from the University's COVID-19 vaccination requirement. Requiring vaccination against COVID-19 complies with the executive order relating to employers who serve as federal contractors and demonstrates our commitment to protect the safety and health of our students, employees, and the University community. Individuals requesting a medical accommodation must complete this form per the instructions below.

- You must complete this form and provide supporting documentation as requested.
- You must then submit the completed request form to Human Resources at hrbp@memphis.edu.
- Upon review of the completed form and documentation, you will be notified of the decision regarding your requested accommodation.
- The University may require you to reapply for approved accommodation(s) annually.
- Per the CDC, the following are NOT considered contraindications to COVID-19 vaccination and accommodations will not be granted:
  - -Local injection site reactions after (days to weeks) previous COVID-19 vaccines (erythema, induration, pruritus, pain, etc.)
  - -Expected systemic vaccine side effects in previous COVID- 19 vaccines (fever, chills, fatigue, headache, lymphadenopathy, vomiting, diarrhea, myalgia, arthralgia)
  - -Vasovagal reaction after receiving a dose of any vaccination
  - -Being an immunocompromised individual or receiving immunosuppressive medications
  - -Autoimmune conditions, including Guillain-Barre Syndrome
  - -Allergic reactions to anything not contained in the COVID-19 vaccines, including injectable therapies, food, pets, venom, environmental allergens, oral medication, latex, etc.
  - -Immunosuppressed person in the employee's household
  - -Alpha-gal Syndrome
  - -The COVID vaccines do not contain egg or gelatin, allergies to these substances are not contraindication

SECTION I: MEDICAL ACCOMMODATION REQUEST

Name: _____ Banner ID:_____

Department: _____ E-Mail:_____

Please provide the qualifying medical condition that a medical provider considers a contraindication to the COVID-19 vaccine, consistent with CDC guidance (Use space below and additional sheet(s) as needed).

Please ensure your healthcare provider completes Section II of this form.

I verify that the above information is complete and accurate, and I understand that any intentional misrepresentation contained in this request may result in disciplinary action. I also understand my request for an accommodation may not be granted if it is not reasonable or if it creates an unduehardship or direct threat to the University community.

Signature: _____ Date:_____

SECTION II: HEALTHCARE PROVIDER CERTIFICATION

Please provide the following information:

Note to Provider: Answer, fully and completely, all applicable parts. Please attach supporting documentation/medical documentation as appropriate.

Name of Patient:_____

Patient should not be immunized for COVID-19 for the following reason(s): (Please be as specific as possible including the medical condition that is a contraindication for the COVID-19 vaccine consistent withCDC guidance and the duration of the qualifying medical condition.)

I certify that Patient has the above contraindication and recommend that they not receive the COVID-19 vaccination as a result of the above contraindication.

Healthcare Provider's Name *(please print)*:_____

Specialty: _____ **Phone Number:** _____

Street Address: _____ **City/State/ZIP:** _____

Healthcare Provider's Signature: _____ **Date:** _____

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family memberof the individual, except as specifically allowed by this law. To comply with this law, we are asking that younot provide any genetic information when responding to this request for medical information. "Genetic Information" as defined by GINA includes an individual's family medical history, the results of an individual'sor family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

FOR HUMAN RESOURCES ONLY

Date Received:_____ **Medical Accommodation approved?** Yes_____ No_____

Signature of HRBP processing request: _____ Date approved/denied: _____

Conditions of approval (if any):

Reason denied (if applicable):