MEDICAL EXEMPTION TO COVID-19 VACCINATION REQUEST FORM

ATTACHMENT H
HSC OP
June , 2023

To assist in the assessment of your medical exemption request, please provide a statement below explaining the medical reason you are seeking an exemption from the COVID-19 vaccine:

I understand that the Non-TTUHSC Facility COVID Mandate requires that I be fully vaccinated against COVID-19 to continue to work or learn at the Non-TTUHSC Facility. I am requesting to be exempted from the Non-TTUHSC Facility COVID Mandate because of a medical condition/disability.

I understand that even if my medical exemption is granted by TTUHSC, other health care organizations may still exclude me from their facilities. Furthermore, I understand that if I am granted a medical exemption, I may still be subject to testing and other public health requirements or measures that may not apply to vaccinated individuals. If granted access on an exemption basis to any site that requires vaccination, I agree to comply with all public health measures in place for unvaccinated individuals at such site.

I verify that the information I am submitting on this form is true and accurate to the best of my knowledge. I also understand that a knowingly false statement on this

SECTION 2: MEDICAL CERTIFICATION FOR VACCINATION EXEMPTION

Dear Health Care Provider,

All TTUHSC employees, students, volunteers and contractors working or learning in a site with a Non-TTUHSC Facility COVID Mandate are required to be vaccinated against COVID-19. The individual named above is seeking an exemption to this requirement due to a medical condition for which vaccines are contraindicated or because the individual is subject to a CDC recommended vaccine deferral. Please complete this form to assist TTUHSC in evaluating this request.

The person named above should not receive the COVID-19 vaccine due to:

This exemption should be: ‘ Temporary, expiring on: / /_____ , or when the following occurs: ‘ Permanent	
I certify the above information to be true and accurate.	
Health Care Provider Name (print):	
Health Care Provider Signature:	Date:
Health Care Practice & Address	Phone: