UCONN HEALTH

UConn Health Mandatory COVID-19 Vaccination Policy
Medical Exemption, Medical Deferral, or Personal Deferral Request

Instructions

Medical Exemptions or Deferrals: If you believe that you have a medical reason that prevents you from receiving the COVID-19 vaccine, you must upload this completed form. You **must** complete Section I, and take the form to your healthcare provider (MD, DO, NP, or PA). Your healthcare provider **must** complete Section II, and provide you with supporting documentation at the time of your visit. Incomplete forms will not be considered. All requests will be reviewed by the Medical Exemption/Deferral Review Committee.

Personal Deferrals: If you are currently out on block leave, pregnant, or breastfeeding, and would like to request a deferral from receiving the COVID-19 vaccination, please complete, sign, and upload Section I. All requests will be reviewed and confirmed by Human Resources. Human Resources may contact you for additional information regarding your request.

SECTION I: INDIVIDUAL COMPLETES THIS SECTION

Name: (Last)	(First)
Date of Birth:	
Position/Job Title:	Employee ID:
Department:	Manager/Supervisor:
Email:	Phone Number:

Please check if you are requesting an exemption or a deferral and provide the condition for which you are seeking exemption or deferral:

☐ I am requesting a *medical exemption* from COVID-19 vaccination.

Condition:

☐ I am requesting a *medical deferral* from COVID-19 vaccination.

Condition:

☐ I am requesting a *medical deferral* from COVID-19 vaccination because of a prior positive COVID-19 test.

Date of Positive Test:

Additional Information:

☐ I am requesting a *personal deferral* from COVID-19 vaccination. By checking this box, I understand that personal deferrals are only permitted for the following circumstances.

Reason for personal deferral:

□ I am currently on block leave.

Details:

□ I am pregnant.

Anticipated Delivery Date:

□ I am actively breastfeeding.

Until (if known):

By signing this form, you hereby authorize the Medical Exemption/Deferral Review Committee and Human Resources to contact you or your medical provider regarding conditions that prevent you from receiving the COVID-19 vaccination. You further agree to comply with any recommended protective requirements as provided by state or federal guidelines or UConn Health policy. If your request for an exemption is not approved, and you do not otherwise receive a deferral of this requirement, you will be required to receive the COVID-19 vaccine as a condition of your continued employment. **Individuals who have been denied an exemption shall have ten (10) days from the date of the notice of the denial to receive the vaccine (either a single dose vaccine or first dose of the 2-dose vaccine).**

You understand that by signing this form, if granted an exemption or deferral, your name and vaccination status will be shared to the extent necessary to ensure compliance with health and safety requirements for unvaccinated individuals. You agree to comply with these restrictions and accept the responsibility for compliance with all health and safety requirements. You acknowledge that if your request is approved, you will be exempted or deferred from receiving the COVID-19 vaccine and you may be required to comply with all of the following:

- **Receive a weekly COVID-19 NAAT or PCR testing.**
- **Must follow the present travel guidelines for out-of-state travel with HR documentation and obtain a COVID-19 NAAT or PCR (not rapid antigen) test before returning to work following any out-of-state travel that lasts 24 hours or more. Additional testing following travel may be required under the instruction of the COVID-19 Call Center clinicians.**
- **Be required to wear a mask at all times while working on site and required to wear protective eyewear when providing clinical care to all patients and an N95 or equivalent respirator when performing any aerosol-generating procedure on any patient.**

Updates to these requirements may be made based on evolving state and federal public health guidance and will be communicated with employees.

By signing below, I acknowledge that I have read and understand the previous statements, and agree to comply as applicable.

Signature:_____ Date: _____

Printed/Typed name: _____

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SECTION II: MEDICAL PROVIDER COMPLETES THIS SECTION

Step 1: Select the reason for exemption or deferral

□ A documented history of severe or immediate-type allergic reaction to any ingredient of all currently available COVID-19 vaccine brands. List vaccine ingredient(s) the patient is allergic to:

Details:

☐ A documented history of severe allergy or immediate-type hypersensitivity reaction to a previous COVID-19 vaccination, and also a separate contraindication to all currently available COVID-19 vaccine brands.

Details:

☐ For the J&J/Janssen vaccine: A history of a specific heparin allergy known as heparin-induced thrombocytopenia (HIT) may be a contraindication or reason to defer the vaccination.

Details:

☐ Other - medical condition that requires employee to not receive the vaccination or delay until a future date.

Details:

☐ Medication-induced immunocompromised states, especially when the medication is temporary and the vaccine is predicted to have better efficacy with future administration. Ideally though the vaccination should be given at least 2 weeks before the initiation of such immunosuppressive medications.

Details:

☐ Upcoming surgery: If an individual is scheduled for an upcoming surgery, they should consult with the surgeon to determine if their vaccination should be scheduled to a later date.

Details (including when the individual should be able to get vaccinated):

Note: The following conditions are **not** considered medical contraindications to COVID-19 vaccination:

- A history of allergy or anaphylaxis to foods, antibiotics, other oral medications, pets, venom, other environmental allergies, or non-COVID vaccines
- A history of latex allergy

- Individuals who do not eat eggs or gelatin
- Family history of adverse vaccine reactions or autoimmune conditions
- Fear of needles or general avoidance of vaccines

Step 2: Complete the following:

Print Provider's Name: (Last)	(First)
Provider's Street Address:	City/State/Zip Code:
Phone Number:	Fax Number:
Specialty:	

Based on the previous section, provider is recommending:

☐ A medical deferral

Vaccination can be initiated at a date: _____

*Anticipated Duration of temporary deferral:*_____

☐ A medical exemption

☐ Other:

Additional Comments:

Provider Signature: _____

Date: _____

ATTACH MEDICAL RECORDS

Please attach medical records or progress/visit notes that specifically indicate the contraindication/s for the patient receiving the COVID-19 vaccine. **Please note that the entire patient chart is not required -** only the ***progress/visit note*** of the healthcare provider ***demonstrating contraindications to the COVID-19 Vaccine is required.***