REQUEST FOR MEDICAL EXEMPTION FROM COVID-19 VACCINATION REQUIREMENT

Printed Name:______________________________________Date of Birth: ___________________________

Rocket Number:_____________________________________Department/Unit: ________________________

STUDENT/EMPLOYEE TO COMPLETE

I request exemption from the COVID-19 vaccination requirements due to my current medical condition. I understand and assume the risks of non-vaccination and assume full responsibility for my health.

I understand and agree to comply with and abide by all university of Toledo COVID-19 policies and procedures☐ No ☐ Yes

I understand that this exemption is only valid for current academic year, and I may need to submit a new request for any subsequent changes, new medical contraindications, or on expiration of an approved exemption ☐No ☐ Yes

I authorize my qualified licensed health care provider with whom I have an established provider-patient relationship to provide The University of Toledo with medical information about my medical exemption for the COVID-19 vaccination

☐No ☐ Yes

I certify that the information I have provided on and in connection with this request is accurate and complete as of the date of this submission ☐No ☐Yes

Student/Employee Signature: ____________________________________Date: ____________________
(Parent/Guardian if student is under 18)

When form is completed, please submit to: https://utvaccinereg.utoledo.edu/

HEALTHCARE PROVIDER TO COMPLETE

Dear Physician/Practitioner:
The University of Toledo requires COVID-19 vaccination for all students and employees. The above-named person is requesting an exemption from COVID-19 vaccination.

Please certify below the medical reason that your patient should not be immunized for COVID-19 by completing this form and attaching supporting documentation where applicable.

☐ The physical condition of the patient or medical circumstances relating to the individual are such that immunization is not considered safe.
Explanation of contraindication required:

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As a qualified healthcare provider with an established relationship with this patient, I certify on ___________(date) that ____ (print student/employee name) has the above contraindication(s).

Provider Printed Name: ____________________(MD, DO, NP, PA) Medical License # : __________________

Provider Signature: ______________________
(Note: Signature Stamp Not Acceptable)

Provider Address ______________________________ Phone:_______________ Fax: _____________

Questions should be directed to: The University of Toledo University Health Clinic,
Phone: 419.530.3451; Fax: 419.530.3499; email: https://utvaccinereg.utoledo.edu/ Thank you

UNIVERSITY HEALTH STAFF TO COMPLETE:

University Health determination of exemption request: ☐Accepted ☐Not Accepted

Date decision communicated to student/employee: ____________________

Mechanism of communication: ____________________________

Reviewer printed name: ____

Reviewer signature:____Date: _____________________