UNIVERSITY OF CALIFORNIA, BERKELEY

PART 1: MEDICAL EXEMPTION AND/OR DISABILITY EXCEPTION AND/OR PREGNANCY DEFERRAL REQUEST FORM Exception to SARS-CoV-2 (COVID-19) Vaccination Requirement

PART 2: CERTIFICATION FROM HEALTH CARE PROVIDER

The University of California requires that its employees and students be vaccinated against COVID-19 infection as a condition of accessing any University location, facility, or program in person. The University may grant Exceptions to this requirement based on (a) Medical Exemption due to a Contraindication or Precaution to COVID-19 vaccination recognized by the U.S. Centers for Disease Control and Prevention (CDC) or by the vaccines' manufacturers; (b) Medical Exemption due to COVID-19 diagnosis or treatment within the last 90 days; or (c) Disability, provided that the individual's request for such an Exception is supported by a certification from their qualified licensed health care provider.

PART 1: MEDICAL EXEMPTION AND/OR DISABILITY EXCEPTION AND/OR PREGNANCY DEFERRAL REQUEST

Employees must check one of the following, sign, date, and submit this form to initiate the request for an Exception or Deferral. Employees must also promptly submit the Medical Certification portion of this form to finalize/complete their request for an Exception request within the timelines set forth in the policy (medical certification is not needed for a Pregnancy Deferral request). If the Medical Certification portion is not timely received, the Exception will be denied.

- ☐ Contraindication or Precaution to COVID-19 Vaccination
- ☐ COVID-19 Diagnosis or Treatment Within Last 90 Days
- ☐ Disability That Makes COVID-19 Vaccine Inadvisable
- ☐ Deferral Request Due to Pregnancy

PART 2: CERTIFICATION FROM HEALTH CARE PROVIDER

HEALTH CARE PROVIDER NAME	LICENSE TYPE, # AND ISSUING STATE
FULL NAME OF PATIENT	DATE OF BIRTH OF PATIENT
PATIENT'S EMPLOYEE/STUDENT/TRAINEE ID NUMBER	HEALTH CARE PROVIDER PHONE/EMAIL
PHYSICIAN SUPERVISOR AND LICENSE # (FOR A PHYSICIAN ASSISTANT WORKING UNDER A PHYSICIAN'S LICENSE)	

Please note the following from the Genetic Information Nondiscrimination Act of 2008 (GINA), which applies to all University employees:

> *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 member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not 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's or 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.*

Please complete Part A of this form if one or more of the Contraindications or Precautions to COVID-19 vaccination recognized by the CDC or the vaccines' manufacturers apply to this patient. Please complete Part B if this patient has been diagnosed with or treated for COVID-19 within the last 90 days. Please complete Part C if this patient has a Disability, as defined below, that makes COVID-19 vaccination inadvisable in your professional opinion. The patient can complete Part D (no physician signature required) if the patient is requesting a Deferral due to pregnancy. More than one section may be completed if applicable to this patient.

Important: Do not identify the patient's diagnosis, disability, or other medical information (other than COVID-19 diagnosis in Part B) as this document will be returned to the University.

Part A: Contraindication or Precaution to COVID-19 Vaccination

☐ I certify that one or more of the Contraindications or Precautions recognized by the CDC or by the vaccines' manufacturers for each of the currently available COVID-19 vaccines applies to the patient listed above. For that reason, COVID-19 vaccination using *any* of the currently available COVID-19 vaccines is inadvisable for this patient in my professional opinion.

The Contraindication(s) and/or Precaution(s) is/are:

☐ Permanent ☐ Temporary. If temporary, the expected end date is: _____ .

Part B: COVID-19 Diagnosis or Treatment Within Last 90 Days

☐ I certify that the patient listed above has been diagnosed with or treated for COVID-19 within the last 90 days.

☐ My patient's COVID-19 diagnosis or last day of treatment (whichever is later) was on: _____

☐ My patient is being actively treated for COVID-19. The expected end date of treatment is: _____

Part C: Disability That Makes COVID-19 Vaccination Inadvisable

☐ I certify that the patient listed above has a Disability, as defined above, that makes COVID-19 vaccination inadvisable in my professional opinion.

The patient's disability is:

☐ Permanent ☐ Temporary. If temporary, the expected end date is: _____ .

Health Care Provider Signature (Required for Parts A, B, or C):

_____ _____

Signature of Health Care Provider Date

Part D: Deferral Request Due to Pregnancy (physician signature not required)

This form should be used by University employees to request a Deferral of the COVID-19 vaccination requirement in the University's SARS-CoV-2 Vaccination Program Policy during pregnancy.

☐ I am currently pregnant and am requesting a Deferral of the COVID-19 vaccination requirement during my pregnancy. My anticipated due date is: _____

While my request is pending, I understand that I must comply with the Non-Pharmaceutical Interventions (e.g., face coverings, regular asymptomatic testing) for unvaccinated or not fully vaccinated individuals as a condition of my Physical Presence at any University Location/Facility or Program. These required Non-Pharmaceutical Interventions are defined by my Location's public health, environmental health and safety, occupational health, or infection prevention authorities, including the Location Vaccine Authority. I also understand that I must comply with any additional Non-Pharmaceutical Interventions applicable to my circumstances or position, as required by my Location. If my request is granted, I understand that I will be required to comply with Non-Pharmaceutical Interventions specified by my Location as a condition of my Physical Presence at any University Location/Facility or Program.

I verify the truth and accuracy of the statements in this request form.

Employee Signature: _____ Date: _____

Date Received by University: _____ By: _____