CASE WESTERN RESERVE UNIVERSITY EST. 1826

STUDENT REQUEST FOR MEDICAL EXEMPTION FROM MANDATORY COVID-19 VACCINATION POLICY – MEDICAL PROVIDER CERTIFICATION

The information requested in this form may be provided via email to disability@case.edu or directly placed in the form below.

Case Western Reserve University's (CWRU) Mandatory COVID-19 Vaccination Policy requires that, by July 23, 2021, all faculty, staff, and students whose work or study requires their presence on campus must establish that they are fully vaccinated, i.e., it has been two weeks since they have received their final dose of an approved COVID-19 vaccine. The individual named below requested a medical exemption from CWRU's Mandatory COVID-19 Vaccination Policy. Please review the below prior to evaluating the individual named above, and then complete this form to assist CWRU in evaluating the individual's request for an accommodation. The information will be treated confidentially and only shared with only those who have a need to know.

STUDENT INFORMATION

FIRST NAME: _______________ MIDDLE INITIAL: ___ LAST NAME: _________________________

DATE OF BIRTH: ____________

DIAGNOSTIC INFORMATION

TO: MEDICAL CARE PROVIDER

1. How long has this student been under your care? ___________________________________

2. Is the student currently under your care? Yes No

3. Does the individual have a mental or physical impairment or other medical condition that does or may interfere with his or her ability to receive any one of the approved COVID-19 vaccinations?[1]

   YES NO

If you answer NO, you may STOP, SIGN THE FORM, and return it to CWRU.

4. If you answered YES to Question 3, describe in detail the nature of the mental or physical impairment or other medical condition.

[1] We do not need you to respond with any information about any condition that has absolutely no bearing on the ability of the individual to receive one of the COVID-19 vaccinations. You may answer "No" to this question if they have a condition, but in your medical opinion, it has no limitations or restrictions that would in any way interfere with the ability of the named individual to receive one of the COVID-19 vaccinations.

5. Identify all approved COVID-19 vaccinations (*e.g.* Pfizer-BioNTech, Moderna, Johnson & Johnson's Janssen) that, in your medical opinion, the named individual should not receive due to the impairment or other medical condition identified in response to Question 4 above.

6. Explain how the impairment or medical condition above does or may interfere with the named individual's ability to receive the COVID-19 vaccination(s) you identified in response to Question 5 above.

7. How long is the mental or physical impairment or other medical condition identified in response to Question 4 likely to last?

   The impairment/condition commenced on: ________________________

   The impairment/condition is likely to last until: ______________________

   Further comments:

8. The requested exemption from CWRU's Mandatory COVID-19 Vaccination Policy should be:

   ☐ **Temporary, expiring on: ___/___/______, or when ___________________________.**

   ☐ **Permanent.**

9. To the extent that CWRU could potentially provide the named individual with a medical exemption from CWRU's Mandatory COVID-19 Vaccination Policy, CWRU may implement additional safety procedures, including mask obligations, physical distancing, and testing requirements. Could the named individual safely comply with these additional procedures?

   YES NO

   If no, please explain which additional safety procedures the named individual could not safely comply with and a detailed explanation as to why.

10. Please provide any additional information you believe would be helpful to CWRU in evaluating the named individual's request for a medical exemption from CWRU's Mandatory COVID-19 Vaccination Policy.

I certify the above information to be true and accurate, and request exemption from the COVID-19 vaccination(s) identified above for the individual named above.

Contact information:

Address: ____

Telephone: ____

FAX and/or Email address: ______________________________________

Printed Name: ___________________________________

Professional Signature: ______________________________

License #: ____________________ **Date:** ______________

Thank you for taking the time to complete this form. If we need additional information, we may contact you at a later date. Please return a completed copy of this form or send an email with the relevant information in it to Disability Resources in Sears 402, 216-368-8826, or at disability@case.edu.