MEDICAL EXEMPTION FROM COVID-19 VACCINATION REQUIREMENT

INSTRUCTIONS:

This Form:

1. Must be completed by an employee who is requesting an exemption from the requirement to complete vaccination against COVID-19;
2. is only valid for application for exemptions from the requirement to complete vaccination against COVID-19;
3. Must be submitted to **HR@NJCU.edu**, along with all supporting documentation and materials. An application is not complete and will not be considered without the required documents attached (see below). The University will review each application and will contact the employee within five business days of receipt to request any supporting documentation, or to provide notice that the application is complete as submitted. If such a request is made, the employee has a maximum of ten business days to submit additional materials as requested. If a request for exemption is denied, an amended application can be submitted within ten business days. No more than one amended version of an application may be submitted.

ACCOMPANYING DOCUMENTATION:

- Medical Exemptions: Employees with a medical condition or disability that prevents them from receiving a COVID-19 vaccination may qualify for a medical exemption pursuant to the Americans with Disabilities Act. Employees seeking a medical exception ***must submit a doctor's note*** *describing how or why the employee's medical condition or disability prevents the employee from receiving the COVID-19 vaccine and cite the CDC guidelines pertaining to that medical issue by the deadline stated above.*

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RELATED PROTOCOLS:

1. All employees, except those with approved religious and medical exemptions, must be fully vaccinated against COVID-19, which vaccination must be complete by December 23, 2021.

2. Employees hired after September 7, 2021 must be fully vaccinated against COVID-19, *including adjunct faculty.*

3. Individuals who are unvaccinated, **including those with an exemption**, are required to comply with COVID-19 testing and screening protocols, as well as other health and safety protocols as may be implemented by the University in order to mitigate the spread of COVID-19.

4. The term of approval for an exemption is up to 180 days. No less than 30 days from the expiration date of an exemption, the University will provide notice via University e-mail of the upcoming expiration. An employee may apply for a new term of exemption by submitting a new complete application within 30 days of the receipt of notice of the upcoming expiration.

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(additional pages may be attached)

Employee Section: Complete the following information

Name (last, first):

Employee ID:

Email Address:

Phone Number:

I verify that the information I am submitting in support of my request for an exemption is complete and accurate to the best of my knowledge, and I understand that any intentional misrepresentation contained in this request may result in disciplinary action.

Employee Signature:

Provider Section: TO BE COMPLETED **ONLY** BY A LICENSED PHYSICIAN, PHYSICIAN'S ASSISTANT OR NURSE PRACTITIONER. ***Forms completed by the employee will not be accepted.***

Physician/Provider Instructions: By completing this form, you certify that different methods of vaccinating against COVID-19 have been considered, and that the following medical contraindication precludes any/all vaccinations for COVID-19. Guidance for medical exemptions for COVID-19 vaccination can be obtained from the Advisory Committee on Immunization Practices (ACIP) available at https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html.

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Please select medically indicated contraindication below:

___ Severe allergic reaction (anaphylaxis) after a previous dose of or to a component of the COVID- 19 Vaccine, including Polyethylene Glycol (PEG) (Please describe response in detail below and contraindication to alternatives, such as the Johnson & Johnson vaccine, which does not contain PEG)

___ Immediate allergic reaction to a previous dose or known (diagnosed) allergy to a component of the vaccine (Please describe response in detail below and contraindication to alternative vaccines.)

___ Other medical circumstance preventing vaccination with any available COVID-19 vaccine (Be specific & describe in detail below, additional pages may be attached)

_____

_____

_____

_____

Signature of Healthcare Provider: _____

Date: _____

Printed name: _____

Practice telephone number: _____

AFFIX STAMP BELOW: