CCFMG
Central California Faculty Medical Group

University | Centers of Excellence
In affiliation with UCSF Fresno

Central California Faculty Medical Group
MEDICAL EXEMPTION AND/OR DISABILITY EXCEPTION REQUEST FORM
Exception to SARS-CoV-2 (COVID-19) Vaccination Requirement

CERTIFICATION FROM HEALTH CARE PROVIDER

The Central California Faculty Medical Group (CCFMG) requires that its employees and students be vaccinated against COVID-19 infection as a condition of accessing any work location. CCFMG 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.

Health Care Provider Name	*License Type, # and Issuing State*
Patient's Full Name	*Patient's Date of Birth*
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.*

Fill out 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.

Fill out Part B if this patient has been diagnosed with or treated for COVID-19 within the last 90 days.

Fill out Part C if this patient has a Disability, as defined below, that makes COVID-19 vaccination inadvisable in your professional opinion. 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 CCFMG.***

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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 my patient 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

"Disability" is defined as a physical or mental disorder or condition that limits a major life activity and any other condition recognized as a disability under applicable law. "Disability" includes pregnancy, childbirth, or a related medical condition where reasonable accommodation is medically advisable.

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: _____

_____ _____

Signature of Health Care Provider Date