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

Employee Name	
Job Title	*Location*
Department (If Applicable)	*Supervisor (If Applicable)*
Phone Number	*Email*

This form should be used by Central California Faculty Medical Group (CCFMG) employees to request an Exception to the COVID-19 vaccination requirement in CCFMG's SARSCoV-2 Vaccination Program Policy 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.

Fill out Part A to request a Medical Exemption due to Contraindication or Precaution.
Fill out Part B to request a Medical Exemption due to COVID-19 diagnosis or treatment within the last 90 days.
Fill out Part C to request an Exception based on Disability. More than one section may be completed if applicable.
Important: ***Do not identify any diagnosis, disability, or other medical information (other than COVID-19 diagnosis in Part B). That information is not required to process your request.***

Part A: Request for Medical Exemption Due to Contraindication or Precaution

❑ The Contraindications or Precautions to COVID-19 vaccination recognized by the CDC or by the vaccines' manufacturers apply to me with respect to all available COVID-19 vaccines. For that reason, I am requesting an Exception to the COVID-19 vaccination requirement based on Medical Exemption. My request is supported by the attached certification from my health care provider. ***I understand that some local (city/county) public health departments have issued orders specifying that the certification must be signed by a physician, nurse practitioner, or other licensed medical professional practicing under the license of a physician.***

Part B: Request for Medical Exemption Due to COVID-19 Diagnosis or Treatment

❑ I have been diagnosed with or treated for COVID-19 within the last 90 days. For that reason, I am requesting an Exception to the COVID-19 vaccination requirement based on Medical Exemption. My request is supported by the attached certification from my health care provider. ***I understand that some local (city/county) public health departments have issued orders specifying that the certification must be signed by a physician, nurse practitioner, or other licensed medical professional practicing under the license of a physician.***

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Part C: Request for Exception Based on Disability

❑ I have a Disability and am requesting an Exception to the COVID-19 vaccination requirement as a Disability accommodation. My request is supported by the attached certification from my health care provider. I understand that some local (city/county) public health departments have issued orders specifying that the certification must be signed by a physician, nurse practitioner, or other licensed medical professional practicing under the license of a physician.

Please provide any additional information that you think may be helpful in processing your request. ***Again, do not identify your diagnosis, disability, or other medical information.***

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 work location. 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 work location.

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

Employee Signature _____ Date _____

Date Received by CCFMG _____ By _____