Request for Medical Accommodation Related to COVID-19 Vaccine

To request a medical accommodation from Utica College's requirement for submission of COVID-19 vaccination documentation, please complete section 1 below and have your medical provider complete section 2. Once completed, students may return this form to the Student Health and Wellness Center (via email at health@utica.edu, or deliver in person to the Student Health and Wellness Center in Strebel Student Center). Employees may return the form to the Office of Human Resources (via email at hr@ utica.edu, or deliver in person to Addison Miller White Hall 124).

Section 1

Name (print):	Date:
Dept.:	Position:
Supervisor:	Work/Cell Phone:

I am requesting a medical accommodation related to Utica College's COVID-19 requirement for confirmation of COVID-19 vaccination.

I verify that the information I am submitting to substantiate my request for accommodation is true and accurate to the best of my knowledge. I understand that any falsified information can lead to disciplinary action.

I further understand that Utica College is not required to provide this accommodation if doing so would pose a direct threat to others in the living/learning environment or in workplace, or would create an undue hardship for Utica College.

Signature:	Date:

Section 2

Medical Certification for Vaccination Accommodation

Student or Employee Name: ____

Dear Medical Provider,

Utica College requires confirmation of receipt of COVID-19 vaccination as a condition of on-campus College attendance or employment. The individual named above is seeking an exemption to this policy due to medical contraindications.

Please complete this form to assist Utica College in the student accommodation/reasonable accommodation process.

The person named above should not receive the COVID-19 vaccine due to (specify the individual's diagnosis and why the COVID-19 vaccine may be detrimental to the individual's health or is otherwise medically contraindicated for the individual): ____________________________

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This exemption should be:

☐ Temporary, expiring on: ____________, or when _________________________________

☐ Permanent

I certify that I have a professional provider/patient relationship with the individual named above and that the above information is true and accurate, and I request exemption from the College's requirement to submit confirmation of COVID-19 vaccination for the above-named individual.

Medical Provider Name (print):	
Medical Provider Signature:	Date:
Practice Name & Address:	Provider Phone:

STUDENT HEALTH AND WELLNESS CENTER/HUMAN RESOURCES USE ONLY

Date of initial request: ______________ Date certification received: ______________

Accommodation request:

☐ Approved ______________

Describe specific accommodation details:

____

☐ Denied ______________

Describe why accommodation is denied:

____