University of Colorado
Denver | Anschutz Medical Campus

Candidate Request for Medical Exemption From COVID Vaccination Requirement

Pursuant to the University of Colorado Anschutz Medical Campus COVID-19 Vaccination Requirement Policy, all University of Colorado Anschutz Medical Campus community members, including all employees[1] and badged affiliates[2] are required to be immunized against COVID-19. However, the University recognizes medical exemptions where vaccination would endanger an individual's life or health or is medically contraindicated due to other medical conditions. Under either of these circumstances, the University requires the individual to submit this medical exemption form.

To be completed by school, college or department:

For notification **only** of exemption request outcome (no medical information will be shared)
Position Title: _____ Position Number: _____
Interviewing School/College/Department: _____
Business Partner Name: _____ Business Partner Email: _____

To be completed by candidate:

Candidate Name: _____

Candidate Phone Number: _____ Candidate Email: _____

Candidate or Badged Affiliate Statement of Exemption

I am hereby claiming a medical exemption from vaccination against COVID-19. The information I have provided on this form is complete and accurate. I understand that by receiving a medical exemption fromthe COVID-19 vaccination, I may be required to follow CU Anschutz policies and procedures that apply to individuals who are not vaccinated against COVID-19.

REQUIRED Signature: _____

Date: _____

*****Below portion to be completed by the Employee's Health Care Provider (CO licensed MD, DO, NP, PA only)*****

Please review safety, allergy and other information regarding exemptions to the COVID-19 vaccinationseries at the following links.
COVID-19 Vaccines While Pregnant or Breastfeeding, Safety of COVID Vaccines, Frequently Asked Questions about COVID-19 Vaccination | CDC

[1] The term "employees" includes, but is not limited to, staff, faculty, post-doctoral fellows, medical residents and fellows.

[2] The term "badged affiliates" includes, but is not limited to, any individual who has a CU Anschutz badge to access campus facilities, including badged contractors and employees at affiliated institutions who have CU Anschutz badges and access campus facilities on a regular basis.

Medical reasons for requested exemption (check all that apply):

1. Pfizer/Moderna vaccine series:

☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to vaccine components

☐ Allergy to specific component of the vaccine (please specify:_____)

2. Johnson and Johnson vaccine series:

☐ Personal history of Guillain-Barre Syndrome within 6 weeks of receiving any vaccine.

☐ Severe allergic reaction (e.g. anaphylaxis after a previous dose or to vaccine components

☐ Allergy to specific component of the vaccine (please specify:_____)

3. For any COVID-19 vaccination series, **we will accept pregnancy as a temporary exemption while each of the COVID-19 vaccines are under emergency use authorization.** Please indicate estimated date of conception (EDC) below and document verified pregnancy. Lactation alone is not a category for exemption:

☐ Documented Pregnancy (please indicate EDC:_____)

We will accept pregnancy as a temporary exemption while each of the COVID-19 vaccines are under emergency use authorization. Please indicate estimated date of conception (EDC) and document verified pregnancy.

4. Other condition

☐ Specify _____

Please provide documentation and indicate whether this medical contraindication is permanent or temporary and timeframe for re-evaluation if less than 1 year. Please attach documentation to support the diagnosis and assessment.

Provider Statement of Exemption

The physical condition of the above named employee or badged affiliate is such that vaccination would endanger their life or health or is medically contraindicated due to other medical conditions as specified above.

REQUIRED Provider **Name:**_____

Provider Signature:_____

Provider License Number: _____

Date: _____

Physician (MD, DO), Advanced Practice Nurse (APN), or Physician Assistant (authorized pursuant to section 12-240-107 (6), C.R.S.)