COPPIN STATE UNIVERSITY
EST. 1900

REQUEST FOR MEDICAL EXEMPTION FROM COVID-19 VACCINATION

If you have an allergy to the COVID-19 vaccine or a specific medical condition that precludes the COVID-19 vaccination requirement and you seek a medical exemption from CSU's COVID-19 vaccination requirement, please consult with your physician and provide the following information.

Please print the following information:

Name: _____ **Date of Birth:** _____

E-mail: _____ **Phone No.:** _____

Supervisor (employees)**:** _____ **Department/School:** _____

Physician Name: _____ **Physician Phone No.:** _____

Physician Address: _____

Dear Physician:

Coppin State University, as mandated by the University System of Maryland, requires COVID-19 vaccinations for all students, faculty and staff. A medical exemption from COVID-19 vaccination is allowed for certain recognized contraindications (https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html).

Please complete the form below. Should you have any questions, please contact:

Faculty/Staff/Vendors: Email AskHR@coppin.edu or call (410) 951-3666
Students: Email Healthcenter@coppin.edu or call (410) 951-4188

The above person should not be immunized for COVID-19 for the following reasons (Please check all that apply):

☐ **Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a component of the COVID-19 vaccine**

☐ **Immediate allergic reaction of any severity to a previous dose or known (diagnosed) allergy to a component of the vaccine (Vaccine Ingredients: https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html#Appendix-C)**

Which ingredient caused an allergic reaction? _____

What was the reaction? _____

Which brand of the COVID-19 vaccine is contraindicated and why? _____

_____

_____

How long will the medical contraindication last? _____

☐ **Other Medical Reason – Please provide this information in a separate narrative that describes the other medical reason justifying an exemption in detail.**

FOR THE PHYSICIAN

I certify that _____ has the above contraindication or specific medical condition and request a medical exemption from COVID-19 vaccination.

Physician Signature: _____ **Date:** _____
(Note: Signature Stamp Not Acceptable)

Physician Medical License No.: _____ **NPI No.:** _____

FOR THE REQUESTOR (Student/Faculty/Staff)

Verification and Accuracy:

I verify that the above information 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 which may include termination/dismissal (faculty/staff) and suspension/expulsion (students). I also understand that my request for an exemption may not be granted if it creates an undue hardship for the University.

Signature: _____ **Date:** _____

Print Name: _____

CSU ID No.: _____

Signature of Parent or Guardian (if <18 years old): _____

Print Name: _____ **Date:** _____

Confidentiality of Information Provided

Requests for exemptions and any documents provided will be kept confidential and shared only with those university employees who have a need to know.

Please complete the form below. Should you have any questions, please contact:

Faculty/Staff/Vendors: Email AskHR@coppin.edu
Students: Email Healthcenter@coppin.edu

Summary of Next Steps:

1. Receipt of this medical exemption request will be acknowledged by the University Health Center (students) and the Office of Human Resources (faculty and staff).
2. You will be notified of the decision regarding your requested medical exemption.
3. If you are granted a medical exemption, you will be required to undergo COVID-19 testing in addition to observing all COVID-19 health and safety protocols.
4. Coppin State University will reconsider a denial only if you bring forth new information supporting your request. For reconsideration of a denial, please contact the Office of Human Resources (for faculty/staff) and the Office of Student Affairs (for students).

DESIGNATED OFFICE USE ONLY:
Medical Exemption Approved Date: _____ Approving Staff Signature: _____
Name/ Title: _____