CLEAR FORM

UNIVERSITY of HAWAI'I®
SYSTEM

Request for Temporary Medical Exemption from COVID-19 Testing

(For ***Unvaccinated*** Employees)

In order to be eligible to return to campus after being diagnosed with a recent COVID-19 infection you must complete this form and submit this and the following to your campus Covid-19 Response team (you can find a list here: https://www.hawaii.edu/covid19/covid-19-info-by-campuses/) via UH File Drop (https://www.hawaii.edu/filedrop/) services.

1. Provide a copy of initial positive COVID-19 test result or a letter from a medical provider documenting test result/and or onset of illness date.
2. Letter from medical provider with date of release from isolation and clearance to return to campus.

All documents must be on official medical provider-issued letterhead and submitted with this form for processing. Please allow a week for processing.

SECTION A: ***To be completed by employee***

Employee's Name: _____ UH ID/Username: _____

Phone: _____ UH Email Address:_____ UH Home Campus: UH MANOA

By signing below: I understand that as I have recently (within the last 90 days) tested positive for COVID-19, I will be considered exempt from the testing requirement for 90 days from the date of my positive case. I understand that I may not return to campus or attend any in-person activities until I am officially cleared by my medical provider and should isolate for the recommended duration as advised by my medical provider. I further understand that once cleared by my medical provider, I must continue to comply with University rules and regulations pertaining to COVID-19.

Employee's Signature: _____ Date: _____

SECTION B: ***To be completed by Healthcare Professional ONLY (MD, DO, APRN-Rx, PA)***

Date of positive laboratory-confirmed (RT-PCR or antigen) COVID-19 infection:_____(Date)

This exemption from testing begins/began on:_____ and ends on: _____
(date: Year/Mo/Day) (date: Year/Mo/Day - 90 days from test)

Employee is/was cleared to return to campus *[after their required 10 day isolation and without fever for 24 hours and resolution of symptoms*] on: _____(Date)

I certify that this employee is considered compliant for 90 days from the date of the positive case.

_____ _____ _____
Healthcare Professional Name/Title (print) Healthcare Professional Signature Date

Address:_____ License Number:_____

For Office Use Only:
Received By: _____ Date: _____