UNIVERSITY of HAWAI'I SYSTEM

Request for Employee Exemption from COVID-19 Vaccination on Medical Grounds

Effective August 23, 2021, the University is requiring that all students, employees, volunteers, and visitors be fully vaccinated against COVID-19 or regularly obtain a negative COVID-19 test result. To request an exemption from the vaccine based on medical grounds, complete this form and submit it to your Departmental Human Resources Specialist.

SECTION A: TO BE COMPLETED BY EMPLOYEE

Name: _____ UH ID / Username: _____

Phone: _____ UH Email Address: _____ Campus /Dept: _____

BY SIGNING BELOW: I understand that by not receiving a vaccination, I will be more susceptible to disease caused by the SARS-CoV-2 virus or its variants, for which the vaccination offers protection from severe COVID-19 disease that may result in hospitalization or death, and hereby release the University of Hawai'i from any and all claims I may have as a result of contracting such a disease.

I further understand that, as a result of not having received the vaccination, I will be subject to required testing as directed by University of Hawai'i policy, and that failure to regularly test and submit my test results for review may result in disciplinary action, up to and including discharge.

Employee Signature: _____ Date: _____

SECTION B: TO BE COMPLETED BY A HEALTHCARE PROFESSIONAL ONLY (MD, DO, APRN-Rx, PA). A medical exemption from the COVID-19 vaccination is being requested based upon the following contraindication(s) and/or precaution(s):

Contraindications:

☐ 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 allergy to a component of the vaccine.

Precautions:

☐ History of immediate allergic reaction to a vaccine or injectable therapy

☐ Moderate to severe acute illness

This exemption begins on ____/_____/_____ (Date) and ends on _____/_____/_____ (Date)

I certify that in my medical judgment, due to the contraindication(s)/precaution(s) noted above, this employee is exempt from the specific COVID-19 vaccine(s) named: _____

_____ _____ _____

Healthcare Professional Name/Title (Print) Healthcare Professional Signature Date

Phone Number: _____ License Number:_____