HAMLINE UNIVERSITY

COVID-19 Medical Exemption Form for Employees

To request a medical exemption from the COVID-19 vaccine requirement please complete Section A and then have your Health Care Provider complete Section B before returning this form to the Benefits Office.

A.) To be completed by employee:

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

Employee Acknowledgement

I understand and acknowledge by applying for a medical exemption from the COVID-19 vaccination requirement, I will not have the protections afforded by the vaccine. Therefore, I understand that in the event of an outbreak, potential epidemic or epidemic of a vaccine-preventable disease, the University may suspend me from the University, restrict my University activities or require other precautions, for my own protection or the protection of others, until the threat has passed. This may include following the mask policy, current quarantine for exposure guidelines, isolation for positive test guidelines, regular scheduled testing and any other guidelines put in place for the safety of the Hamline community.

I knowingly and voluntarily agree to assume the risks associated with being an employee at the University without the vaccine intended to prevent COVID-19.

By signing below, I understand all the above and the information I am submitting is true and accurate to the best of my knowledge. I understand that any falsified or misleading information can lead to disciplinary action, up to and including termination.

Signature: _____

Date: _____

Release of Information

My signature above authorizes the release of the following information to Hamline University, Benefits Office or any other person who is authorized by Hamline University to receive medical information that is specifically related and necessary to determine the medical exemption/reasonable accommodation in the workplace for COVID-19. I further authorize the Benefits Office or others as authorized by Hamline University to contact my physician or health care provider, if necessary, to seek clarification of this documentation.

B.) To be completed by Physician or Health Care Provider

Hamline University requires vaccination against COVID-19 as a condition of employment. The above-named employee is requesting an exemption from the policy due to medical reasons.

1) I certify that my patient named above should not receive the COVID-19 vaccine due to the medical contraindication:

2) This exemption should be:

- ☐ Temporary, expiring on ____/___/___ or when _____
- ☐ Re-evaluate, near the date of ___/___/___
- ☐ Permanent

If there are any questions about this form, please contact the Benefits Administrator at 651-523-2815 or ccarlson28@hamline.edu

Authorization of Information Provided
Physician/Health Care Provider Name:
Physician/Health Care Provider Signature:
Date Signed:
Telephone Number:

Please return completed form to the Benefits Office at Hamline University as soon as possible via confidential fax at 651-523-3055. Thank you for your assistance!