University Health

Request for Accommodation - COVID-19 Vaccine Contraindication Form To be Completed by Provider

Part 1: To be completed by the Vendor's employee

Name:_____ Date of Request:_____

Vendor Name: _____ Position/Job Title:_____

Department:_____ Location(s):_____

University Health is committed to providing a safe, inclusive, and supportive experience for all and recognizes a medical accommodation may be necessary to University Health's vaccination requirements. University Health will carefully review all requests for accommodation, approval is not guaranteed.

This form is to be used to apply for a medical accommodation to the University Health Policy 6.07, Attachment I: Vendor Representative COVID-19 Vaccination Procedures. It must be completed and submitted to the VENDORS.VAX@uhs-sa.com and HR.Vax.Requests@uhs-sa.com. Your due date is: **February 21, 2022**.

You will be notified in writing of the outcome of this request. Please note that your Request for Accommodation may be submitted to a panel for further review, and that your attendance and participation in a discussion about your request may be required.

Part 2: To be completed by the treating provider

Your patient,_____**,** has requested an accommodation. University Health has a vaccine policy that requires vendors to take certain vaccine(s) every year. *Your patient,* has communicated that he/she has a disability that prevents him/her from having certain vaccine(s) administered. University Health has engaged in a flexible, interactive process to analyze and evaluate your patient's request for an accommodation under the Americans with Disabilities Act (ADA).

According to University Health Policy 6.07, Attachment I: Vendor Representative COVID-19 Vaccination Procedures, the COVID-19 vaccine is mandatory for vendors who provide services on site. Please indicate which reason(s) are contraindications to the required vaccines listed below:

COVID-19 (for all positions)

- ☐ Recent monoclonal antibody within 90 days
- ☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a component of the COVID-19 vaccine
- ☐ Immediate (within 4 hours of exposure) allergic reaction of any severity to a previous dose or known (diagnosed) allergy to a component of the vaccine

Please indicate the medical condition that prevents your patient from receiving the vaccination(s).

Is this a temporary or permanent medical condition/disability?

- ☐ Temporary and will be able to receive any vaccination(s) on_____.
- ☐ Permanent

I, as the patient's provider, attest that the above checked reasons are verified contraindications for my patient.

_____ _____

Provider Signature Date

_____ _____

Provider Printed Name and Title Licensure Number

_____

Address and Phone Number

Please return form via **email** to University Health at: VENDORS.VAX@uhs-sa.com and HR.Vax.Requests@uhs-sa.com.

You may visit the following website for further information:
https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.pdf