LAKEVIEW
COLLEGE OF NURSING
ADAPTABILITY • CARING • EXCELLENCE • INTEGRITY • SERVICE

REQUEST FOR MEDICAL EXEMPTION AND/OR DISABILITY EXCEPTION

Exception to SARS –CoV-2 (COVID-19) Vaccination Requirement

Print Name:	Date:
Email:	
☐ Faculty ☐ Student	☐ Danville ☐ Charleston

Lakeview College of Nursing faculty and students should use this form to request an Exception to the COVID-19 vaccination requirement based on:

(a) Medical Exemption due to a Contraindication or Precaution to COVID-19 vaccination recognized by the U.S. Centers for Disease Control and Prevention (CDC) or by the vaccines' manufacturers;
(b) Medical Exemption due to COVID-19 diagnosis or treatment within the last 90 days; or
(c) Disability.

Fill out Part A to request a Medical Exemption due to Contraindication or Precaution.
Fill out Part B to request a Medical Exemption due to COVID-19 diagnosis or treatment within the last 90 days.
Fill out Part C to request an Exception based on Disability.

More than one section may be completed if applicable.

Important: Do not identify any diagnosis, disability, or other medical information (other than COVID-19 diagnosis in Part B). That information is not required to process your request.

Part A: Request for Medical Exemption Due to Contraindication or Precaution

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The Contraindications or Precautions to COVID-19 vaccination recognized by the CDC or by the vaccines' manufacturers apply to me with respect to all available COVID-19 vaccines. For that reason, I am requesting an Exception to the COVID-19 vaccination requirement based on Medical Exemption. My request is supported by the attached certification from my health care provider. I understand that some local (city/county) public health departments have issued orders specifying that the certification must be signed by a physician, nurse practitioner, or other licensed medical professional practicing under the license of a physician

Part B: Request for Medical Exemption Due to COVID-19 Diagnosis or Treatment

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I have been diagnosed with or treated for COVID-19 within the last 90 days. For that reason, I am requesting an Exception to the COVID-19 vaccination requirement based on Medical Exemption. My request is supported by the attached certification from my health care provider. I understand that some local (city/county) public health departments have issued orders specifying that the certification must be signed by a physician, nurse practitioner, or other licensed medical professional practicing under the license of a physician.

Part C: Request for Exception Based on Disability

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I have a Disability and am requesting an Exception to the COVID-19 vaccination requirement as a Disability accommodation. My request is supported by the attached certification from my health care provider. I understand that some local (city/county) public health departments have issued orders specifying that the certification must be signed by a physician, nurse practitioner, or other licensed medical professional practicing under the license of a physician.

Please provide any additional information that you think may be helpful in processing your request.

Again, do not identify your diagnosis, disability, or other medical information.

While my request is pending, I understand that I must comply with the NonPharmaceutical Interventions (e.g., face coverings, distancing, testing as required) for unvaccinated or not fully vaccinated individuals as a condition of my Physical Presence at either College location or any clinical placement facility. These required NonPharmaceutical Interventions are defined by the public health, environmental health, and safety, occupational health, or infection prevention authorities, including clinical agencies. I also understand that I must comply with any additional Non-Pharmaceutical Interventions applicable to my circumstances or position, as required by the College or clinical placement facility. If my request is granted, I understand that I will be required to comply with Non-Pharmaceutical Interventions specified by the College or clinical agency as a condition of my Physical Presence at either College location or clinical agency.

☐ I verify the truth and accuracy of the statements in this request form.

Faculty/Student Signature: _____ Date: _____

Date Received by College: _____ By: _____

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Exception to SARS –CoV-2 (COVID-19) Vaccination Requirement

Part A: Contraindication or Precaution to COVID-19 Vaccination

I certify that one or more of the Contraindications or Precautions recognized by the CDC or by the vaccines' manufacturers for each of the currently available COVID19 vaccines applies to the patient listed above. For that reason, COVID-19 vaccination using any of the currently available COVID-19 vaccines is inadvisable for this patient in my professional opinion. **Do not identify the diagnosis, disability, or other medical information.**

The Contraindication(s) and/or Precaution(s) is/are:

☐ Permanent ☐ Temporary If temporary, the expected end date is: _____

Part B: COVID-19 Diagnosis or Treatment Within Last 90 Days

I certify that my patient has been diagnosed with or treated for COVID-19 within the last 90 days.

My patient's COVID-19 diagnosis or last day of treatment (whichever is later) was on: _____

My patient is being actively treated for COVID-19. The expected end date of treatment is: _____

Part C: Disability That Makes COVID-19 Vaccination Inadvisable

"Disability" is defined as a physical or mental disorder or condition that limits a major life activity and any other condition recognized as a disability under applicable law. "Disability" includes pregnancy, childbirth, or a related medical condition where reasonable accommodation is medically advisable.

Do not identify the diagnosis, disability, or other medical information.

I certify that the patient listed above has a Disability, as defined above, that makes COVID-19 vaccination inadvisable in my professional opinion. The patient's disability is:

☐ Permanent ☐ Temporary If temporary, the expected end date is: _____

_____ _____

Signature of Health Care Provider Date:

Date Received by College: _____ By: _____