CHICAGO STATE UNIVERSITY

MEDICAL EXEMPTION/ACCOMMODATION REQUEST FORM

For the COVID-19 Vaccination Requirement

To request an exemption/accommodation from Chicago State University's (the "University") employee COVID-19 vaccination requirement, please complete Section 1 below and have your medical provider complete Section 2 before returning this form to the Human Resources Department. The requested information will be used by Human Resources or other appropriate personnel to engage in an interactive process to determine whether or not you are eligible for such an exemption/accommodation and if so, to determine the reasonable accommodations which can be provided that would enable you to perform the essential functions of your position without posing a threat of harm to self or others. Medical exemptions/accommodations for the COVID-19 vaccine will be considered if you provide a written certification (Section 2) by a licensed, treating medical provider [a physician (MD or DO), nurse practitioner (NP), or other licensed medical professional practicing under the license of a physician], of one of the following:

1. The Contraindications or Precautions to COVID-19 vaccination recognized by the CDC or by the vaccines' manufacturers apply to you with respect to all U.S. available COVID-19 vaccines.
2. A statement that your physical condition/ medical circumstances are such that immunization is not considered safe; indicating the specific nature and probable duration of the medical condition or circumstances that contraindicate immunization with the COVID-19 vaccine.

SECTION 1 - ***To Be Completed by Employee***

Name (print):	Date:
Dept.:	Title/Position: UID:
Manager/Supervisor:	Work Phone: Cell Phone:

While my request is pending, I understand that I must comply with non-pharmaceutical interventions (e.g., face coverings, regular asymptomatic testing, etc.) for unvaccinated or not fully vaccinated individuals as a condition of my physical presence at any University location/facility or program. These required non-pharmaceutical interventions are defined by State and local public health, environmental health and safety, occupational health, or infection prevention authorities. I also understand that I must comply with any additional non-pharmaceutical interventions applicable to my circumstances or position, as required by the University. If my request is granted, I understand that I will be required to continue to comply with non-pharmaceutical interventions specified by the University as a condition of my physical presence at any University location/facility or program.

I verify that the information I am submitting to substantiate my request for exemption/accommodation from the University's employee COVID-19 vaccination requirement is true and accurate to the best of my knowledge. I understand that any falsified information can lead to disciplinary action, up to and including termination.

I further understand that the University is not required to provide this exemption if doing so is not reasonable, if it would pose a direct threat to myself or others in the workplace and/or if it would create an undue hardship for the University.

Employee Signature:	**Date:**
Received by Human Resources Representative: Print: Initials:	**Date:**

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CERTIFICATION FROM HEALTH CARE PROVIDER

SECTION 2 - ***To Be Completed by Employee's Medical Provider***

Employee Name (Print): _____

Dear Medical Provider:

Chicago State University requires vaccination against COVID-19 as a condition of employment. The individual named above is seeking an exemption from this vaccination requirement due to medical contraindications.

Please complete this form to assist Chicago State University in the exemption/accommodation process.

The individual named above should not receive the COVID-19 vaccine due to the following reasons:
(Please check all that apply.)

-------- One or more of the Contraindications or Precautions recognized by the CDC or by the vaccines' manufacturers for each of the currently available COVID-19 vaccines applies to the individual listed above.

------- The physical condition of the person or medical circumstances relating to the person are such that immunization is not considered safe. Please indicate the specific nature and probable duration of the medical condition or circumstances that contraindicate immunization with the COVID-19 vaccine.

This exemption should be:

- ☐ Temporary, expiring on: _____/_____/____, or when _____
  MM DD YY
- ☐ Permanent

I certify the above information to be true and accurate, and request exemption from the COVID-19 vaccination for the above-named individual.

Medical Provider Name (print):	License Type, # and Issuing State:
Medical Provider Signature:	Date:
Practice Name & Address:	Provider Phone/Email:
Medical Provider Supervisor and License # (For a Physician Assistant Working Under a Physician's License)	

<u>SECTION 3</u> - ***To Be Completed by Human Resources***

HR USE ONLY

Date this Request Form Received in Human Resources: ____/____/____

Interactive Discussion Dates(s), if applicable:

Exemption/ Accommodation Request:

- ☐ Approved ____/____/____
  Describe Exemption/Accommodation details:

  This approval is valid: _____ until (Date) _____
  _____ indefinitely

  If Exemption/Accommodation is granted, describe required alternative safety precautions:

- ☐ Denied ____/____/____
  Describe why exemption is denied:

Name of Human Resources Representative: _____

Signature of Representative: _____

Date: _____