COMMUNITY COLLEGE OF RHODE ISLAND

COVID-19 Vaccination Medical Exemption Form

Name:________________________________ Birth date_____/____/________ CCRI ID: ___________
(Please print clearly) **Month Day Year**

Department: ____

Faculty and non-classified employees may apply for a medical exemption for a COVID-19 vaccination for the following reasons:

- Severe allergic reaction (e.g., anaphylaxis) after previous dose or to a component of the vaccine
- Immediate allergic reaction of any severity after a previous dose or known (diagnosed) allergy to a component of the vaccine
- History of myocarditis or pericarditis after a first dose of an mRNA COVID-19 vaccine
- History of myocarditis or pericarditis unrelated to mRNA COVID-19 vaccination
- Monoclonal Antibody Treatment (MABS) prior to 90 days of October 1, 2021 (the faculty member or non-classified employee should get vaccinated no later than 91 to 120 days after MABS)
- Faculty and non-classified employees out of work on long-term medical leave, or medical documentation from a treating provider indicating need for exemption

I have been offered a COVID-19 vaccine, provided with information about its safety and efficacy, and am aware of CCRI's COVID-19 vaccination policy.

I am being informed of the following:

Initial___________COVID-19 is a serious disease that has killed more than 500,000 people in the United States.

Initial___________COVID-19 vaccination is recommended for me and for all other members of the CCRI community to protect me and other members of the campus community from COVID-19 and its complications, including serious illness and death.

Initial___________If I contract COVID-19, I may spread the virus for 10-14 days without exhibiting symptoms, which may place family, friends and other community members at risk.

Initial___________I understand that I cannot get COVID-19 from the COVID-19 vaccines.

If I chose to request a medical exemption, I acknowledge the following:

Initial___________I understand that CCRI must approve all exemption requests and may require additional specialty evaluation as part of that process.

Initial___________I understand that individuals who are not vaccinated against COVID-19 because they received a medical exemption **may be required to follow additional health and safety precautions not applicable to fully vaccinated individuals** including but not limited to:

- Regular asymptomatic testing
- Masking and social distancing
- Daily health checks
- Isolation if I test positive for COVID-19 and quarantine if I am identified as a close contact of a person who tests positive
- Restrictions on travel, and required testing and/or quarantine following travel
- Limitations of access to certain events, spaces, roles and activities

Further, I understand that I can change my mind at any time and receive a COVID-19 vaccination.

Despite these facts, I am requesting an exemption from vaccination because I have one of the medical contraindications to COVID-19 vaccine listed below.

- ❒ Severe allergic reaction (e.g., anaphylaxis) after previous dose or to a component of the vaccine
- ❒ Immediate allergic reaction of any severity after a previous dose or known (diagnosed) allergy to a component of the vaccine
- ❒ History of myocarditis or pericarditis after a first dose of an mRNA COVID-19 vaccine
- ❒ History of myocarditis or pericarditis unrelated to mRNA COVID-19 vaccination
- ❒ Monoclonal Antibody Treatment (MABS) prior to 90 days of October 1, 2021 (the faculty member or non-classified employee should get vaccinated no later than 91 to 120 days after MABS)
- ❒ Faculty and non-classified employees out of work on long-term medical leave, or medical documentation from a treating provider indicating need for exemption

➢ **Please attach documentation of the reason for your exemption request from your medical provider using the attached form. Additional information may be requested if needed to make a determination.**

I have read and understand the information on this form.

Signature:____ Date:____________________

Exemption forms must be completed and uploaded to humanresources@ccri.edu no later than October 15, 2021.

COMMUNITY
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OF RHODE ISLAND

Patient Name____**DOB:**_____________**CCRI ID:** __________

Department: ____

Medical Provider Documentation for Covid Vaccination Exemption Request

You have been asked to provide documentation supporting a request for medical exemption from CCRI's COVID-19 vaccination requirement for all student. Please include your medical opinion and all pertinent data supporting your opinion, as indicated below. Attach additional pages asneeded.

Medical Provider Name and Title: ____

Specialty:_____________________**Institution/Practice Name:** ________________________________

Contact phone number:__________________________**Email address:** ________________________

Medical condition or medication warranting exemption. Please be specific. In the event of prior vaccine reactions, please specify the vaccine and the nature of the reaction. Allergy to PEG must be documented as severe or immediate-type reaction**.**

Supporting data (please include any pertinent labs or studies, specialist progress notes):

Exemption is temporary and vaccination can be initiated at a future date: ❒ Yes ❒ No

Anticipated duration of temporary exemption: _________________

Medical Provider Name (printed): ____

Signature:____**Date:** ______________