University of South Alabama Health

Exemption Request form

Request to claim an exemption from the COVID-19 vaccination
for medical reasons or sincerely held religious beliefs.

Staff Information			
Name:	Jag#:		Date:
Email:	Work phone:		Cell Phone:
Current Address:			
City:	State:		Zip code:
Department/School:	Supervisor's name: _____ Supervisor's Phone #:		

Any USA Health Staff as defined in the USA Health Mandatory Vaccination Policy may claim an exemption for medical reasons or because the vaccination conflicts with sincerely held religious beliefs, or both. You may request either a medical or a religious exemption from the COVID-19 vaccination by completing this form and submitting the form to Human Resources. In the event your exemption request is denied, you have a right to file an appeal with the Department of Labor within 7 days. USA Health Human Resources will provide you with information on how to file an appeal.

I am requesting exemption from the COVID-19 vaccine requirements for one of the following reasons (check all that apply):

- ☐ My healthcare provider has recommended to me that I refuse the COVID-19 vaccination based on my current health conditions and medications. (NOTE: You must include a licensed healthcare provider's signature on this form to claim this exemption.)
- ☐ I have previously suffered a severe allergic reaction (e.g., anaphylaxis) related to vaccinations in the past. (NOTE: You must include a licensed healthcare provider's signature on this form to claim this exemption.)
- ☐ I have previously suffered a severe allergic reaction related to receiving polyethylene glycol or products containing polyethylene glycol. (NOTE: You must include a licensed healthcare provider's signature on this form to claim this exemption.)
- ☐ I have previously suffered a severe allergic reaction related to receiving polysorbate or products containing polysorbate. (NOTE: You must include a licensed healthcare provider's signature on this form to claim this exemption.)
- ☐ I have received monoclonal antibodies or convalescent plasma as part of a COVID-19 treatment in the past 90 days. (NOTE: You must include a licensed healthcare provider's signature on this form to claim this exemption.)
- ☐ I have a bleeding disorder or am taking a blood thinner. (NOTE: You must include a licensed healthcare provider's signature on this form to claim this exemption.)
- ☐ I am severely immunocompromised such that receiving the COVID-19 vaccination creates a risk to my health. (NOTE: You must include a licensed healthcare provider's signature on this form to claim this exemption.)
- ☐ I have been diagnosed with COVID-19 in the past 12 months. (NOTE: You must include a licensed healthcare provider's signature on this form to claim this exemption.)

- ☐ Receiving the COVID-19 vaccination conflicts with my sincerely held religious beliefs, practices, or observances.

I hereby swear or affirm that the information in this request is true and accurate. I understand that providing false or misleading information is grounds for discipline, up to and including termination from employment.

STAFF Signature:		**Date:**	

(Note: The following must be completed ONLY if claiming one or more of the medical exemptions listed above.)

Signature of Healthcare Provider:	**Date:**