COLUMBIA UNIVERSITY
IN THE CITY OF NEW YORK

Request for Medical Immunization Exemption Form

Name: _____

PID/UNI: _____ School/Department: _____

University Email: _____ Phone: _____

Columbia University policy requires that all students, faculty, and staff receive a COVID-19 vaccination. **A medical exemption may be granted upon receipt of a completed form (below) not more than 6 months old, signed and certified by a licensed healthcare provider, not related to the submitter, and whose specialty is appropriate to the associated condition.**

Medical exemptions expire when the medical condition(s) contraindicating COVID-19 immunization changes in a manner which permits immunization or upon graduation (students), as determined by Columbia University in reviewing the request. The assigned expiration is at the sole determination of Columbia University.

Individuals with an approved exemption may be required to comply with additional testing and other preventive requirements. In the event of an outbreak on or near campus, individuals holding exemptions may be excluded from all campus facilities and activities, for their protection, until the outbreak is declared to be over.

A committee of human resources and trained medical professionals will carefully review all requests, though approval is not guaranteed. Your name is redacted from your submission before it is shared with the committee. All sensitive medical information will be kept confidential, only shared on a need-to-know basis, and stored separately, consistent with University protocols. Please allow at least 15 business days for your request to be processed and forwarded for committee review. After your request has been reviewed and processed, you will be notified, in writing, if an exemption has been granted or denied. If the approved exemption contains an expiration, you will be expected to complete the requirement at that time. Should the condition continue, or a new immunization contraindication occur, a new request with updated documentation is required. The decisions of the committee are final and not subject to appeal. Individuals whose requests have been denied are permitted to reapply if new documentation and information should become available.

In order to submit a request, please:

- **Read the CDC COVID-19 Vaccine Information;**
- **Complete the following page of this form;**
- **Have your provider complete the provider section of this form;**
- **Attach all supplemental materials; and**
- **Upload the completed documents via the process described on the ReOpenCU app.**

Note: incomplete submissions will not be reviewed. Be sure all forms and documentation are submitted at one time

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Initial next to each of the statements below:

	I request exemption from the COVID-19 immunization requirements due to my current medical condition. I understand and assume the risks of non-immunization. I accept full responsibility for my health, thus removing liability from Columbia University to the required immunization.
	I understand that as I am not vaccinated, in order to protect my own health and the health of the community, I will comply with assigned COVID-19 testing requirements and other preventive guidance.
	I understand that in the event of an outbreak or threatened outbreak, I may be temporarily excluded or reassigned from University facilities and approved activities (including but not limited to University-owned housing). I agree to comply with these restrictions and accept responsibility for communicating with supervisors, human resources, faculty, and advisors as appropriate to my University affiliation.
	Should I contract COVID-19, I will immediately report it to Columbia University (email to covidtesttrace@columbia.edu) and comply with all isolation and quarantine procedures specified by the University and remove myself from the University community if so advised.
	I acknowledge that I have read the **CDC COVID-19 Vaccine Information**.
	I understand that this exemption will expire when the medical condition(s) contraindicating immunization changes in a manner which permits immunization, as determined by the University in reviewing the request.
	I understand and agree to comply with and abide by all Columbia University policies and procedures.
	I understand that this exception is only valid for the approved period and I may need to submit a new request for any subsequent changes, new medical contraindications, or on expiration of an approved exemption.
	I certify that the information I have provided in connection with this request is accurate and complete. I understand this exception may be revoked and I may be subject to University disciplinary action if any of the information I provided in support of this exemption is false.

Printed Name: _____

Signature: _____

Date: _____

UNI: _____ Columbia Email: _____

Phone number: _____

☐ By checking this box and typing my name above, I am electronically signing this form.

Date: _____

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Attention Health Care Provider:

Columbia University policy requires that all students, faculty, and staff receive a COVID-19 vaccination. _____ (insert patient's name) is requesting a medical exemption from this vaccination requirement. A medical exemption may be allowed for certain recognized contraindications.

Please certify below the medical reason that your patient should not be immunized for COVID-19 by completing this form and attaching available supporting documentation. Information provided on this form will be reviewed by a confidential committee in consideration of the exemption request.

Option 1 - Allergy

☐ A documented history of a severe allergic reaction to any component of a COVID-19 vaccine or to a substance that is cross-reactive with a component. Please indicate which of the following vaccines are contraindicated and name the components, by vaccine NOTE: since egg free vaccine is available, history of egg allergy will not be accepted as a routine medical exemption.

- Moderna - List the component(s): _____
- Pfizer-BioNTech - List the component(s): _____
- Janssen/Johnson&Johnson - List the component(s): _____
- Other - List the component(s): _____

☐ A documented history of a severe allergic reaction after a previous dose of the COVID-19 vaccine

Please indicate to which vaccine the patient had a reaction and the date of the vaccine & reaction

- Moderna - Date of Vaccine & Reaction: _____
- Pfizer - Date of Vaccine & Reaction: _____
- Janssen/Johnson&Johnson - Date of Vaccine & Reaction: _____

Option 2 – Physical Condition/Medical Circumstance

☐ The physical condition of the patient or medical circumstances relating to the individual are such that immunization is not considered safe. Please state, with sufficient detail for independent medical review, the specific nature and probable duration of the medical condition or circumstances that contraindicate immunization with the COVID-19 vaccine.

Explanation:

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Option 3 - Other

☐ Other. Please provide this information in a separate narrative that describes, in detail, the medical condition or disability in detail that you opine would exempt this individual from vaccination:

Explanation:

Certification

I certify that _____ (patient name) has the above contraindication and support the request for a medical exemption from the COVID-19 vaccine requirement at Columbia University.

Provider Information

Medical Provider Name: _____

Medical Provider Specialty: _____

Signature: _____

Provider License Number: _____

Date: _____

Name of Provider Company: _____

Address: _____

Email: _____

Phone number:_____

☐ By checking this box and typing my name above, I am electronically signing this form.

Patient Information

Patient Name: _____

Date: _____

UNI: _____ Columbia Email: _____

Phone number: _____