COUNTY OF SANTA CLARA
MEDICAL EXEMPTION AND/OR DISABILITY EXCEPTION REQUEST FORM
Exception to SARS-CoV-2 (COVID-19) Vaccination Requirement

FULL NAME	EMPLOYEE ID (IF APPLICABLE)
JOB TITLE (IF APPLICABLE)	LOCATION OF WORKSITE
COUNTY DEPARTMENT OR AGENCY	COUNTY SUPERVISOR (IF APPLICABLE)
PHONE NUMBER	EMAIL
NAME OF EMPLOYER/SCHOOL (IF CONTRACTOR OR STUDENT)	

This form should be used by County of Santa Clara employees, contractors, interns, and volunteers (including commissioners) working or volunteering on-site at a County facility or other County location to request an exception to the County's 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; or (b) disability.

Fill out Part A to request an Exception based on Medical Exemption. Fill out Part B to request an Exception based on Disability. Both sections may be completed if both apply to you, and both sections refer to an attached certification form from a qualified licensed health care provider. Important: Do not identify any diagnosis, disability, or other medical information. That information is not required to submit your request.

Part A: Request for Exception Based on Medical Exemption

☐ 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 physician, nurse practitioner, or other licensed medical professional practicing under the license of a physician.

Part B: Request for Exception Based on Disability

☐ 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 licensed physician, nurse practitioner, or other licensed medical professional practicing under the license of a physician.

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Please provide any additional information that you think may be helpful in processing your request. ***Again, do <u>not</u> identify your diagnosis, disability, or other medical information.***

While my request is pending, I understand that I must comply with all other COVID-19 prevention requirements (e.g., face coverings, regular asymptomatic testing) for unvaccinated or not fully vaccinated individuals under County policy and state and local public health directives. If my request is granted, I understand that I will be required to comply with COVID-19 prevention requirements, other than vaccination, as specified.

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

Signature:_____ Date:_____

Name of County Staff Receiving This Request Form: _____

Date Received:_____

PLEASE SUBMIT COMPLETED FORM TO: eodra@eod.sccgov.org

CERTIFICATION FROM PHYSICIAN, NURSE PRACTITIONER, OR OTHER LICENSED MEDICAL PROFESSIONAL PRACTICING UNDER THE LICENSE OF A PHYSICIAN

The County of Santa Clara requires that its employees, contractors, interns, and volunteers (including commissioners) working or volunteering on-site at a County facility or other County location be vaccinated against COVID-19 infection. The County may grant exceptions to this 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 or (b) disability, provided that the individual's request for such an exception is supported by a certification from their qualified licensed healthcare provider.

HEALTH CARE PROVIDER NAME	LICENSE TYPE, # AND ISSUING STATE
FULL NAME OF PATIENT	DATE OF BIRTH OF PATIENT
PATIENT'S EMPLOYEE ID NUMBER (if applicable)	HEALTH CARE PROVIDER PHONE/EMAIL
PHYSICIAN SUPERVISOR AND LICENSE # (FOR A PHYSICIAN ASSISTANT WORKING UNDER A PHYSICIAN'S LICENSE)	

Please complete Part A of this form if one or more of the contraindications or precautions to COVID-19 vaccination recognized by the CDC or the vaccines' manufacturers apply to this patient with respect to* all *FDA-authorized COVID-19 vaccines. Please complete Part B if this patient has a disability, as defined below, that makes COVID-19 vaccination inadvisable in your professional medical opinion. Both sections may be completed if both apply to this patient. Important: Do not identify the patient's diagnosis, disability, genetic information,[1] or other medical information as this document will be returned to the County of Santa Clara, which employs, contracts with, or otherwise works with patient.

[1] Per the Genetic Information Nondiscrimination Act of 2008 (GINA), "genetic information" includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

CERTIFICATION FROM PHYSICIAN, NURSE PRACTITIONER, OR OTHER LICENSED MEDICAL PROFESSIONAL PRACTICING UNDER THE LICENSE OF A PHYSICIAN

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

Part A: Contraindication or Precaution to COVID-19 Vaccination

☐ I certify that _____ is my patient, and that one or more of the contraindications or precautions recognized by theCDC or by the vaccines' manufacturers for each of the currently available COVID-19 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. The contraindication(s) and/or precaution(s) is/are:
☐ Permanent ☐ Temporary.

If temporary, the expected end date is:

Part B: Disability That Makes COVID-19 Vaccination Medically 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 your medical opinion is that COVID-19 vaccination is inadvisable.

☐ I certify that _____ is my patient and has a disability, as defined above, that makesCOVID-19 vaccination medically 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

_____
Medical Specialty

PLEASE SUBMIT COMLETED FORM TO: eodra@eod.sccgov.org