# Carnegie Mellon University
# Application for Medical Exemption from COVID-19 Booster Vaccination

**Name: _____**
**(Print Last, First, Middle)**

**Affiliation (Faculty / Staff): _____**

**Andrew ID (If applicable): _____**

**Email Address: _____**

**Phone Number: _____**

## Instructions for Submission of Application for Medical Exemption from COVID-19 Booster Vaccination:

Please have your medical provider complete and sign the Healthcare Provider Section and Verification portion of this form, and submit the completed form to employeeaccess@andrew.cmu.edu. The medical information that you provide on this form will be kept confidential. Your application will be reviewed, and you will receive a message from Human Resources notifying you of the decision. If your request is granted, you will be marked as compliant with the university's vaccination registration requirement.

Those who are granted a vaccination exemption must comply with all applicable COVID-19 mitigation requirements.

## Attestation:

By signing this application, I am requesting a medical exemption from a booster vaccination for COVID-19 required by Carnegie Mellon University ("CMU") for faculty and staff.

By signing this application, I understand that, for the safety of the campus community, I will be required to comply with CMU's COVID-19 mitigation protocols.

**_____ Date:_____**
**Signature**

**_____ Date:_____**
**Printed Name**

**_____ Date:_____**
**Signature of Parent/Legal Guardian (if under age of 18)**

**_____ Date:_____**
**Printed Name of Parent/Legal Guardian (if under age of 18)**

## Healthcare Provider Section and Verification:

A licensed physician, physician's assistant, or nurse practitioner must complete the medical exemption statement and provide their information below. Forms completed by the faculty or staff member seeking the exemption will not be accepted.

**Healthcare Provider Instructions:** Completing this form verifies that the following medical contraindication precludes booster vaccination for COVID-19.

**Name of Person Seeking a Medical Exemption from COVID-19 Booster Vaccination (Printed):**

_____

**Provide a detailed explanation of the specific medical contraindication requiring a COVID-19 booster vaccine exemption:**

| |
|---|
| |

**Is this condition:**

◯ Temporary (if yes, please specify the anticipated duration).

Anticipated duration: _____

◯ Permanent

**I hereby certify that the above-named patient qualifies for a medical exemption from COVID-19 booster vaccination and that the medical contraindication is well-documented in their health record.**

Signature of Healthcare Provider: _____ Date: _____

Printed Name: _____

Email: _____

Phone: _____

Practice Address: _____