HARTNELL COLLEGE

COVID-19 Medical Exemption Request Form

Name: _____ ID#: _____ Date of Birth: _____

I, _____ (Name of licensed MD, DO, PA, NP) certify that the person listed above has a medical condition that contraindicates his/her/them from receiving a COVID-19 vaccination.

Please check the appropriate box and fill in a description of the contraindication below:

☐ The applicable CDC contraindication to the vaccine, or

☐ The applicable manufacturer's vaccine insert contraindication to this vaccine

REQUIRED: Description of contraindication meeting either criteria above:

This contraindication is: ☐ Permanent OR ☐ Temporary
If temporary, the expiration date of the exemption is: _____

_____ _____
Signature of Licensed Healthcare Provider Date

_____ _____
Printed Name of Healthcare Provider MD/DO/PA/NP

Medical License Number: _____

Office Stamp (Required)