

# Linfield University COVID-19 Vaccine or COVID-19 Vaccine Booster

## Employee Exemption Request Form

Directions: Employees requesting medical exemption must personally complete sections 1 and 4, and their health care provider must complete sections 2 and 4. Employees requesting non-medical exemptions must complete sections 1, 3, and 4-Part B, and their health care provider must complete section 4-Part A. Completed forms should be uploaded into the retrieve portal.

### Section One: Employee Name and Identifying Information

Employee last name: \_\_\_\_\_ Employee first name: \_\_\_\_\_

Employee middle initial: \_\_\_\_\_ ID# \_\_\_\_\_ Linfield email: \_\_\_\_\_@linfield.edu

Phone: \_\_\_\_\_ Date of birth: \_\_\_\_\_

### Section Two: Medical Exemption Request (this section must be completed by medical provider for any employee requesting a medical exemption)

Medical Provider Certification: I certify that my patient (named above) should not be vaccinated against COVID-19 because they have one of the following CDC contraindications:

A history of the following:

- Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a component of the COVID-19 vaccine

List which vaccine or allergic component: \_\_\_\_\_

- Immediate allergic reaction of any severity to a previous dose or known (diagnosed) allergy to a component of the vaccine (see <https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html#Appendix-C> which is defined as any hypersensitivity-related signs or symptoms consistent with urticaria, angioedema, respiratory distress (e.g., wheezing, stridor), or anaphylaxis that occur within four hours following administration. Please describe specific reaction:

- Other documented medical contraindication or precaution-- Please Explain:

Note: Information will be reviewed by medical consultants before approval will be granted.

Name and credentials of healthcare provider (print): \_\_\_\_\_

Signature \_\_\_\_\_ Date: \_\_\_\_\_ Phone: \_\_\_\_\_

### Section Three: Non-Medical Exemption Request (this section must be completed by any employee requesting a non-medical exemption). **Health Care Provider Attestation required.**

- Applying for non-medical exemption request. Please explain reason for request:

Requests for non-medical exemption will be provided in appropriate circumstances.

**Section Four: Health Care Provider and Employee Attestation. Parts A and B below MUST be completed.**

**Part A: Health Care Provider Attestation**

I have reviewed with this employee the benefits and risks of COVID-19 vaccination.

Name and Credentials of Health Care Provider (print): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Phone: \_\_\_\_\_

**Part B: Employee Attestation**

COVID-19 is a highly contagious respiratory virus that affects people of all ages. This virus can cause long-term medical problems and death regardless of age. This virus spreads through respiratory secretions related to speaking, singing, yelling, coughing, and sneezing. Infected individuals can spread the virus to others. Up to 50% or more of people can be infected without realizing it. The COVID-19 vaccines and boosters are very safe and highly effective at preventing hospitalization and death. When large numbers within a population are immunized, viral spread will be significantly limited. Everyone in the community can contribute to this protective approach.

I understand that while Linfield will take reasonable measures to mitigate the spread of COVID-19 among its employees, the University cannot protect any individual employee from all risks associated with contracting the virus. I have received information regarding the benefits and risks of immunizations. I understand that choosing to forego vaccination and/or booster puts me at increased risk for getting the disease with the associated risk of long-term medical problems or death. To minimize risk of viral spread, I understand and agree to the following.

- I will be required to continue to wear a mask (even if mask requirements are discontinued for vaccinated staff) in accordance with Linfield's policies and to undergo testing for COVID-19 in the event of an outbreak of COVID-19 on campus.
- I understand that if I contract the disease, I will need to enter isolation for a period of typically five (5) days during which time I will not be able to attend work.
  - If after five (5) days my symptoms are resolving and I have been fever free for 24 hours without the use of fever reducing medicine, I can return to work and must wear a N-95 or KN-95 mask for an additional five (5) days.
- I further understand that as an unvaccinated individual, if I am exposed to someone with COVID-19, I will be required to take the following steps.
  - Quarantine for 5 days.
  - Obtain a test for COVID-19 between days five (5) and seven (7) following exposure.
  - If you are asymptomatic or symptoms resolve (without fever for 24 hours without fever reducing agent) you may return to campus wearing a N95 or KN95 masks for 5 days.
  - If I develop COVID-19 during my quarantine, my time in isolation could be extended by an additional five (5) days. All time away from work will be reported as PTO or Unpaid Time Off.
- With a full understanding of the information provided to me above, I request to be exempted from Linfield's COVID-19 vaccination and booster requirement, and I accept the potential consequences associated with this decision.

Signature of Employee: \_\_\_\_\_ Date: \_\_\_\_\_

Upload this completed form to your Linfield etrieve portal <https://etcentral.linfield.edu>