Aultman College REQUEST FOR MEDICAL EXCEPTION FROM VACCINATION (*Individual Form*)

Please print information below:

Name: _____ Date of Birth: ___/___/___
E-mail:_____ Personal Phone #:_____
Program: _____ Physician Phone #:_____
Physician Name: _____

I request a medical exception for the COVID-19 vaccination.

Declination of Vaccination:

- I understand that due to my occupational exposure, I may be at risk of acquiring infection. In addition, I may spread airborne infection to patients, other employees, and my family, even if I have no symptoms. This can result in serious infection, particularly in persons at high risk for infection or complications.
- I have received education about the effectiveness of vaccinations as well as the adverse events. I have also been given the opportunity to be vaccinated, at no charge to myself. However, I decline vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring airborne infection, potentially resulting in transmission to patients. If in the future I want to be vaccinated, I can receive vaccination at no charge to me.
- I attest that I will wear a mask at all times while at any Aultman Health Foundation or affiliated property, while working with any patient, while traveling for work, or within six feet of any co-worker or patient.
- I attest I will take any COVID-19 tests required by Aultman.

Signature: _____ Date: _____

Print Name: _____

PLEASE EMAIL OR DROP OFF THIS FORM BY
November 29th, 2021
to: Front Desk, Keri Heppe keri.heppe@aultmancollege.edu
Aultman Health Foundation
2600 Sixth Street SW
Canton, OH. 44710

Medical / Disability Certification for Vaccination Accommodation

Individual Name: _____

Dear Medical Provider,

Aultman Health Foundation and its affiliates ("Aultman") requires vaccination against COVID-19 as a condition of employment/enrollment. The individual named above is seeking an exception to or postponement of vaccination due to medical contraindications and/or because of his/her disability status.

Please complete this form to assist Aultman in the reasonable accommodation process.

The person named above should not receive the following COVID-19 vaccine(s) (check all that apply):

☐ Pfizer-BioNTech ☐ Moderna ☐ Janssen (Johnson & Johnson)

Describe the clinical contraindications for not receiving the COVID-19 vaccine(s):

This accommodation should be:

☐ Temporary, expiring on: __/__/____, or when _____

☐ Permanent

I certify the above information to be true and accurate.

Medical Provider Name (print):	
Medical Provider Signature:	Date:
Practice Name & Address:	Provider Phone:

(Note: THIS IS A MEDICAL-LEGAL DOCUMENT; NO STAMP SIGNATURE)

Summary of Next Steps

1. This request will be completed by the individual requesting a medical accommodation.
2. You will submit your request to the keri.heppe@aultmancollege.edu or front desk by November 29th, 2021
3. You will be notified of the decision and/or the proposed accommodation as soon as administratively possible.
4. If you disagree with the decision or proposed accommodation, please contact Aultman Human Resources.