California State University Dominguez Hills Foundation
Medical Exemption Form

The California State University Dominguez Hills Foundation requires its employees who access a CSU Campus and/or related Program, receive an Approved COVID-19 Vaccine as identified in the CSUDH Vaccination Policy.

An employee may be excused from the vaccine requirement due to a medical (including mental health) condition for which an Approved Vaccine presents a significant risk of a serious adverse reaction. Any medical Exemption must be verified by a certified or licensed healthcare professional.

Employees may use this form to serve as documentation from a certified or licensed healthcare professional to support their declaration.

Instructions:

A Health Care Provider must complete this form to certify that the patient, the Foundation employee, qualifies for medical exemption from receiving an Approved COVID-19 Vaccine.

Do not identify the patient's diagnosis, disability, or other medical information as this document must be returned to the University.

Please note: The Genetic Information Nondiscrimination Act of 2008 (GINA) applies to all employees. The GINA prohibits employers from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law.

To comply with this law, we ask you NOT to provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, 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.

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Employee (Patient) Information

Employee Name	Campus California State University, Dominguez Hills
Employee ID # *Paychex Emp ID number*	Department
Employee E-mail Address	Employee Phone #

Health Care Provider Certification

Health Care Provider Name	License Type, # and Issuing State
Health Care Provider E-mail Address	Health Care Provider Phone #

By signing below, I certify that using any of the currently available COVID-19 vaccines is inadvisable for this patient in my professional opinion.

The expected duration of this patient's inability to receive the vaccine is:

☐ Temporary; through _____

☐ Unknown; further evaluation is necessary by _____

☐ Permanent

_____ _____

Signature of Health Care Provider Date