

Request for a Medical Exemption from the Federal COVID-19 Vaccination Requirement

Executive Order 14042 required federal contractors and subcontractors to be vaccinated against COVID-19. Employees seeking an exemption from the vaccination requirement based on a medical disability should complete the form below to request a medical accommodation. Submission of the completed form will be treated as a request for a disability accommodation and evaluated and decided under Americans with Disabilities Act (ADA) for reasonable accommodation absent undue hardship. Additional information may be requested if needed to evaluate the request. Texas A&M AgriLife will maintain the confidentiality of any medical information provided. Employees who receive an exception or a delay from the vaccination requirement will be required instead to comply with alternative health and safety protocols.

Signing this form constitutes a declaration that the information you provide is true and correct to the best of your knowledge and ability. Any intentional misrepresentation may result in legal consequences, up to and including termination. To request a medical exception or delay from the COVID-19 vaccination requirement using this form:

1. You must complete Part 1 of this form.
2. Your medical provider must complete Part 2 of this form.
3. When both are completed, submit this form to the REDCap portal.

If you have any questions about this form, please email covidexecorder@ag.tamu.edu or contact Texas A&M AgriLife Human Resources at 979-845-2423.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of employees or their family members. In order to comply with this new law, we are asking that you not 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 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.

Part 1 – To be Completed by the Employee

Name _____ UIN _____

Title _____ Unit/Dept _____

Work Email _____ Work Phone Number _____

Supervisor _____

Please describe your job duties:

What is the expected duration of your medical condition? Temporary Long-term

1. Briefly describe your disability/medical condition.

2. Briefly describe the specific accommodation requested.

3. Please explain how your disability or medical condition prevents you from receiving the COVID-19 vaccine, addressing each type available (Moderna, Johnson & Johnson, and Pfizer).

4. If permitted an exemption or delay in taking the vaccine, what types of accommodation would enable you to perform your job duties without presenting a risk of transmission to others?

MEDICAL OR DISABILITY EXEMPTION REQUEST

I am requesting a medical exemption from the requirement for COVID-19 vaccination or a delay because of a temporary condition or medical circumstance. I declare that the information I have provided is true and correct to the best of my knowledge and ability.

Print Name: _____

Employee Signature: _____ Date _____

Part 2 – To be Completed by the Employee’s Medical Provider

Employee Name _____

MEDICAL CERTIFICATION FOR COVID-19 VACCINE EXEMPTION

Dear Medical Provider:

Texas A&M AgriLife requires its employees to be fully vaccinated against COVID-19 pursuant to Executive Order 14042 of the President of the United States. The individual named above is seeking a medical exemption to the requirement for COVID-19 vaccination or a delay because of a temporary condition or medical circumstance. Please complete this form to assist Texas A&M AgriLife in its reasonable accommodation process.

Please provide at least the following information, where applicable:

1. The applicable contraindication or precaution for COVID-19 vaccination, and for each contraindication or precaution, indicate: (a) whether it is recognized by the CDC pursuant to its guidance; and (b) whether it is listed in the package insert or Emergency Use Authorization fact sheet for each of the COVID-19 vaccines authorized or approved for use in the United States;
2. A statement that the individual’s condition and medical circumstances relating to the individual are such that COVID-19 vaccination is not considered safe, indicating the specific nature of the medical condition or circumstances that contraindicate immunization with a COVID-19 vaccine or might increase the risk for a serious adverse reaction; and
3. Any other medical condition that would limit the employee from receiving any COVID-19 vaccine.

Description of the medical condition for which the employee listed above should be exempted from complying with a COVID-19 vaccination requirement:

The condition described above is Temporary Long-term

If this is a temporary condition or medical circumstance, when is it expected to end or expire (allowing for COVID-19 vaccination to begin after the date you provided):

Medical Provider Name/Title: _____

Medical Provider Signature: _____ Date _____