Baker College

MEDICAL VERIFICATION for COVID-19 VACCINE EXEMPTION REQUEST

SECTION I: COMPLETED BY STUDENT

INSTRUCTIONS to the STUDENT: Please complete Section I before giving this form to your medical provider. You have 7 calendar days to return this completed form.

Name: ______________________ ____________ __________________________________
First Middle Last

Telephone Number: (____) _____-__________

Email Address: ____

SECTION II: COMPLETED BY HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: The above student has requested an accommodation exempting the student from the College's COVID-19 vaccination requirement due to a contraindication. Please provide all of the information requested below. You should limit your responses to the condition for which the student is seeking an exemption. Please be sure to sign the form on the last page. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the student's family members, 29 C.F.R. § 1635.3(b).

Provider's name: ____

Provider's business address: ____

Type of practice/medical specialty: ____

Telephone number: (____) _____-__________

1. Describe the student's condition, including diagnosis:

   ____

2. Date condition commenced and probable duration:

   ____

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3. Dates you have treated the student for this condition:

   ____

4. Is the student unable to receive the vaccine for COVID-19? ___No; ___Yes. If yes, please specify why:

   ____

   ____

   ____

5. Are there any accommodations or other measures that would enable the student to receive the vaccine? ___No; ___Yes. If yes, please explain the accommodations:

   ____

   ____

   ____

I certify that I have reviewed the information provided in conjunction with this evaluation and that the information contained on this form is true and complete to the best of my knowledge and belief.

Medical Provider Signature: _________________________________

Date: _______________

Submission

SECTION III: SUBMISSION INSTRUCTIONS

Medical Provider: Please return the completed form to the student named above, by email or in-person.

Student: Please submit completed form to the BC Portal.