COMMUNITY COLLEGE OF RHODE ISLAND

COVID-19 Vaccination Medical Exemption for Faculty/Staff

Name:_________________________________Birth date_____/____/________CCRI ID: __________
(Please print clearly) **Month Day Year**

Department: ____

Faculty and non-classified employees may apply for a medical exemption for a COVID-19 vaccination for the following reasons:

- Severe allergic reaction (e.g., anaphylaxis) after previous dose or to a component of the vaccine
- Immediate allergic reaction of any severity after a previous dose or known (diagnosed) allergy to a component of the vaccine
- History of myocarditis or pericarditis after a first dose of an mRNA COVID-19 vaccine
- History of myocarditis or pericarditis unrelated to mRNA COVID-19 vaccination
- Monoclonal Antibody Treatment (MABS) prior to 90 days of the date this form is being completed (the faculty member or non-classified employee should get vaccinated no later than 91 to 120 days after MABS)
- Faculty and non-classified employees out of work on long-term medical leave, or medical documentation from a treating provider indicating need for exemption

I am aware of CCRI's COVID-19 vaccination policy.

I am being informed of the following:

Initial___________COVID-19 is a serious disease that has killed more than 1,000,000 people in the United States.

Initial___________COVID-19 vaccination is recommended for me and for all other members of the CCRI community to protect me and other members of the campus community from COVID-19 and its complications, including serious illness and death.

Initial___________I understand that I cannot get COVID-19 from the COVID-19 vaccines.

If I chose to request a medical exemption, I acknowledge the following:

Initial___________I understand that CCRI must approve all exemption requests and may require additional specialty evaluation as part of that process.

Initial___________I understand that individuals who are not vaccinated against COVID-19 because they received a medical exemption may be required to follow additional health and safety precautions not applicable to fully vaccinated individuals.

I understand that I can change my mind at any time and choose to be vaccinated against COVID.

I am requesting an exemption from vaccination because I have one or more of the following medical contraindications to COVID-19 vaccine:

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

Immediate allergic reaction of any severity after a previous dose or known (diagnosed) allergy to a component of the vaccine

History of myocarditis or pericarditis after a first dose of an mRNA COVID-19 vaccine

History of myocarditis or pericarditis unrelated to mRNA COVID-19 vaccination

Monoclonal Antibody Treatment (MABS) prior to 90 days of the date of completion of this form (the faculty member or non-classified employee should get vaccinated no later than 91 to 120 days after MABS)

Faculty and non-classified employees out of work on long-term medical leave, or medical documentation from a treating provider indicating need for exemption

Please attach documentation from your medical provider to explain the reason for your exemption request using the attached form.

I have read and understand the information on this form.

Signature:____ Date:____________________

Exemption forms must be completed and emailed to HumanResources@CCRI.edu.

COMMUNITY
COLLEGE
OF RHODE ISLAND

Patient Name____**DOB:**_____________**CCRI ID:** __________

Department: ____

Medical Provider Documentation for COVID Vaccination Exemption Request

You have been asked to provide documentation supporting a request for medical exemption from CCRI's COVID-19 vaccination requirement for all employees. Please include your medical opinion and all pertinent data supporting your opinion, as indicated below. Attach additional pages as needed.

Medical Provider Name and Title: ____

Specialty:_____________________**Institution/Practice Name:** ________________________________

Contact phone number:__________________________**Email address:** _________________________

Medical condition or medication warranting exemption. Please be specific. In the event of prior vaccine reactions, please specify the vaccine and the nature of the reaction. Allergy to PEG must be documented as severe or immediate-type reaction**.**

Supporting data (please include any pertinent labs or studies, specialist progress notes):

Exemption is temporary and vaccination can be initiated at a future date: Yes No

Anticipated duration of temporary exemption: _________________

Medical Provider Name (printed): ____

Signature:____**Date:** ______________