**Covid-19 Vaccination Medical Exemption Form**

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Information:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dear Doctor**:**

Pierce College policy requires all students participating in face-to-face instructional activities to be fully vaccinated from COVID-19. Students with a verified medical condition or disability that prevents them from receiving the vaccine can apply for an exemption to be eligible to participate in face-to-face instruction.

The above-named student has disclosed that they have a medical condition or disability which may prevent them from receiving an authorized COVID-19 vaccine.

We are requesting you complete the following form to help us to understand whether the student named above has a medical condition or disability which prevents them from receiving an authorized COVID-19 vaccine.

1. Are you licensed to practice in the state of Washington? Yes \_\_\_ No \_\_\_
	1. If yes, license #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	2. If no, but are licensed in another state, what state and #?
	State: \_\_\_\_\_\_\_\_\_\_\_\_\_ License #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. What is your area of practice and/or medical expertise? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (student name) has disclosed they have a medical condition or disability that may prevent them from receiving an authorized COVID-19 vaccine. Can you confirm this medical condition/disability?

 Yes \_\_\_ No \_\_\_

1. What is the anticipated duration of the medical condition or disability which prevents this person from receiving an authorized COVID-19 vaccination?

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, declare that, in my professional opinion, the above responses are true and accurate, to the best of my knowledge and ability.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date