University Health

Request for Medical Accommodation - Vaccine Contraindication Form
To be Completed by a Licensed Provider

Part 1: To be completed by the individual requesting the accommodation

Name: _____ Date of Request: _____

Position/Job Title: _____ Employee ID No: _____

Department: _____ Location: _____

University Health is committed to providing a safe, inclusive, and supportive experience for all and recognizes a medical accommodation may be necessary to University Health's vaccination requirements. University Health will carefully review all requests for accommodation. Approval is not guaranteed and may be denied if it is determined that approval of the exemption poses a direct threat to the health and safety of University Health's staff and its patients or if it would otherwise create an undue hardship.

This form is to be used to apply for a medical accommodation to the University Health Vaccination Policy. If you are an employee of University Health or a student, the form must be completed and submitted to HR.Vax.Requests@uhs-sa.com. If you are a healthcare provider with privileges to work in University Health facilities, the form must be completed and submitted to pss@uhtx.com.

You understand that you may not be retaliated or discriminated against for requesting and receiving an exemption. You also understand that being required to wear protective medical equipment or being reassigned or prohibited from having contact with patients is not considered retaliatory or discriminatory under state law.

You will be notified in writing of the outcome of this request. Please note that your Request for Accommodation may be submitted to a panel for further review, and that your attendance and participation in a discussion about your request may be required. You hereby consent to the release of this request and any supporting documentation to the panel or any other representatives of University Health on a need-to-know basis in order for the representatives to carry out their duties and to act on your request for an exemption.

<u>Part 2</u>: To be completed by the treating provider

Your patient, _____, has requested a medical accommodation for the University Health vaccine requirements. University Health has a vaccine policy that requires all employees, house staff, physicians, advanced practice providers, students and other personnel either to receive vaccinations as a condition of employment, contract, privileges, enrollment, or service or to receive an approved accommodation.

Your patient has communicated that he/she has a disability that prevents him/her from having certain vaccine(s) administered. University Health has engaged in a flexible, interactive process to analyze and evaluate your patient's request for an accommodation under the Americans with Disabilities Act (ADA). If applicable, please indicate which specific vaccine contraindications specified by the Advisory Committee on Immunization Practices (ACIP)/Centers for Disease Control and Prevention (CDC) apply to your patient as listed below.

Hepatitis A Vaccine (for designated food service positions)

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

Hepatitis B (for all positions that handle blood/body fluids)

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

_____ Hypersensitivity to yeast

Influenza (for all positions)

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

Meningococcal (for designated laboratory positions)

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

MMR (for all positions)

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

_____ Pregnancy

_____ Known severe immunodeficiency (e.g., from hematologic and solid tumors, receipt of chemotherapy, congenital immunodeficiency, long-term immunosuppressive therapy or patients with HIV infection who are severely immunocompromised)

_____ Family history of altered immunocompetence

Tdap (for all positions)

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

_____ Encephalopathy (e.g., coma, decreased level of consciousness, prolonged seizures), not attributable to another identifiable cause, within 7 days of administration of previous dose of DTP, DTaP, or Tdap

Varicella (for all positions)

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

_____ Pregnancy

_____ Known severe immunodeficiency (e.g., from hematologic and solid tumors, receipt of chemotherapy, congenital immunodeficiency, long-term immunosuppressive therapy or patients with HIV infection who are severely immunocompromised)

_____ Family history of altered immunocompetence

Does your patient have a medical condition/disability that prevents him/her from receiving any vaccination(s)?

_____ No (if no, sign and date the bottom of page)

_____ Yes (if yes, continue with questions below)

Please indicate the medical condition that prevents your patient from receiving the vaccination(s).

If your patient is medically unable to receive a specific vaccination, indicate the vaccination(s) your patient is unable to receive.

Is this a temporary or permanent medical condition/disability?

_____ Temporary and will be able to receive vaccination(s) on _____.

_____ Permanent

I, as the patient's provider, attest that the above selected reasons are verified contraindications for my patient.

Provider Signature	Date
Provider Printed Name and Title	Licensure Number
Office Address	
Phone Number	