VENTURA COUNTY COMMUNITY COLLEGE DISTRICT
EMPLOYEE MEDICAL EXEMPTION REQUEST FORM

CERTIFICATION FROM HEALTH CARE PROVIDER

The Ventura County Community College District ("District") requires that its employees and students be vaccinated against COVID-19 infection as a condition of accessing any District location, facility, or program in person. The District may grant Exceptions to this requirement based on (a) Medical Exemption due to a Contraindication or Precaution to COVID-19 vaccination recognized by the U.S. Centers for Disease Control and Prevention (CDC) or by the vaccines' manufacturers or (b) Medical Exemption due to COVID-19 diagnosis or treatment within the last 90 days.

HEALTH CARE PROVIDER NAME	LICENSE TYPE, # AND ISSUING STATE
FULL NAME OF PATIENT	DATE OF BIRTH OF PATIENT
HEALTH CARE PROVIDER PHONE/EMAIL	
PHYSICIAN SUPERVISOR AND LICENSE # (FOR A PHYSICIAN ASSISTANT WORKING UNDER A PHYSICIAN'S LICENSE)	

Please note the following from the Genetic Information Nondiscrimination Act of 2008 (GINA), which applies to all District employees:

> *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 an individual or family member of the individual, except as specifically allowed by this law. To comply with this 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 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.*

Please complete Part A of this form if one or more of the Contraindications or Precautions to COVID-19 vaccination recognized by the CDC or the vaccines' manufacturers apply to this patient. Please complete Part B if this patient has been diagnosed with or treated for COVID-19 within the last 90 days. More than one section may be completed if applicable to this patient. <u>Important</u>: Do not identifythe patient's diagnosis, disability, or other medical information (other than COVID-19 diagnosis in Part B) as this document will be returned to the District.

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Part A: Contraindication or Precaution to COVID-19 Vaccination

☐ I certify that one or more of the Contraindications or Precautions recognized by the CDC or by the vaccines' manufacturers for each of the currently available COVID-19 vaccines applies to the patient listed above. For that reason, COVID-19 vaccination using *any* of the currently available COVID-19 vaccines is inadvisable for this patient in my professional opinion. The Contraindication(s) and/or Precaution(s) is/are:
☐ Permanent ☐ Temporary.

If temporary, the expected end date is: _____.

Part B: COVID-19 Diagnosis or Treatment Within Last 90 Days

☐ I certify that my patient has been diagnosed with or treated for COVID-19 within the last 90 days.

☐ My patient's COVID-19 diagnosis or last day of treatment (whichever is later) was on _____.
☐ My patient is being actively treated for COVID-19. The expected end date of treatment is: _____.

_____ _____
Signature of Health Care Provider Date