UTTyler
THE UNIVERSITY OF TEXAS AT TYLER

MEDICAL CERTIFICATION FOR COVID-19 VACCINATION EXEMPTION

Part 1 and Part 2 must be completed to receive an approved medical exemption.

Part 1 – To Be Completed by the Student/ Faculty

Name:____

email: ______________________ **UT Tyler ID:** _____________________

mRNA vaccines
I cannot receive either mRNA vaccine (Pfizer or Moderna) due to history of anaphylaxis or other significant allergic reaction I cannot receive either mRNA vaccine (Pfizer or Moderna) due to the following medical reason:
Johnson & Johnson vaccine
I cannot receive the Johnson & Johnson vaccine due to history of anaphylaxis or other significant allergic reaction I cannot receive the Johnson & Johnson vaccine due to the following medical reason:

________________________________ ____________________________
Signature Date

Part2 – To Be Completed by the Medical Provider

Dear Medical Provider:

The individual named above is seeking an exemption to the COVID-19 vaccination due to medical contraindications. Please complete this form to assist us in the reasonable accommodation process.

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The person named above should not receive the COVID-19 vaccine due to the following reason (please provide the medical rationale to exclude the employee from the mRNA vaccines as well as the Johnson & Johnson vaccine):

Contraindication:

History of a severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a component of the COVID-19 vaccine

History of a known diagnosed allergy to a component of the COVID-19 vaccine

For the Janssen COVID-19 Vaccine, Thrombosis with Thrombocytopenia Syndrome following receipt of a previous Janssen COVID-19 Vaccine (or other COVID-19 vaccines not currently authorized in the United States that are based on adenovirus vectors, e.g., AstraZeneca)*

This exemption should be:

Temporary, expiring on: , or when

Permanent

This exemption applies to the (check all that apply):

Pfizer-BioNTech Vaccine ModernaTX, Inc.Vaccine Johnson & Johnson vaccine

All of the above

I certify the above information to be true and accurate, and request exemption from the COVID-19 vaccination for the above-named individual.

Medical Provider Name (print):	Provider Phone:
Medical Provider Signature:	Date:
Practice Name & Address:	NPI: License #/State: