Allegany College of Maryland
ALLIED HEALTH PROGRAMS
Medical Certification Form
COVID-19/Influenza Request for Exemption

Student Name (print): _____ **Date**: _____

Dear Health Care Provider,

The above-named student (your patient) has disclosed that he/she has a medical impairment(s) that renders him/her unable to comply with the clinical facilities requirement that students be up-to-date vaccinated (including any recommended boosters) against COVID-19 and/or influenza.

Please complete this form in full to assist the Allegany College of Maryland in the reasonable accommodation process, and return to the above-named employee at your earliest convenience.

The above-named individual has a medical impairment that renders him/her unable to receive the COVID-19 vaccination.

☐ Yes ☐ No

The above-named individual has a medical impairment that renders him/her unable to receive the influenza vaccination.

☐ Yes ☐ No

If you answered "No," do not answer the remaining questions, but complete and sign the "Certification" at the end of this document.

Please describe in detail how the medical impairment(s) renders the student unable to comply with the recommendation to be fully vaccinated against COVID-19 and/or influenza:

This vaccination exemption should be:

☐ Temporary, expiring on: ____/____/_____,
☐ Indefinite

Are there accommodations that will reduce or eliminate the threat of injury/harm posed to the student's own health and/or safety – or the health/safety of others in the clinical setting – while the student is in class given that the student is not fully vaccinated against COVID-19?

☐ Yes ☐ No

Are there accommodations that will reduce or eliminate the threat of injury/harm posed to the student's own health and/or safety – or the health/safety of others in the clinical setting – while the student is in class given that the student is not fully vaccinated against influenza?

☐ Yes ☐ No

If you answered "Yes," please describe <u>all</u> such accommodations in detail and explain how these accommodations will reduce or eliminate the threat:

CERTIFICATION

By signing below, I certify that the answers provided in response to the above questions are based on my own personal knowledge of the relevant medical facts from my own examination of the student, and/or based on my own review of the relevant medical documentation, and my answers represent my professional medical opinion.

Health Care Provider Name (print):	
Health Care Provider Signature:	Date:
Health Care Practice & Address:	Phone:
Health Care Specialty or Type of Practice:	Fax Number:

Student: Once this form has been completed, please return to: ahvaccinewaivers@allegany.edu