UNMC faculty, students, and staff must be fully vaccinated against COVID-19 by October 22, 2021. All employee requests for ADA (medical) exemptions from this requirement must be submitted via this form before September 15, 2021. [https://www.unmc.edu/news.cfm?match=27686](https://www.unmc.edu/news.cfm?match=27686)

If you are an employee and are requesting an ADA (medical) exemption, please complete this form and submit it to the UNMC HR- Employee Relations office at EmployeeRelations@UNMC.edu. A representative from Employee Relations will contact you about your request and will provide detailed instructions regarding next steps.

**Part 1 – To Be Completed by Employee**

| Name: ____________________________ | Job Title: ____________________________ |
| UNMC Personnel # _______________ | Phone Number: ____________________________ |
| Email: ____________________________ | Department: ____________________________ |
| Supervisor: ________________________ | Date of Request: ___________________ |

Reason for ADA (medical) exemption:

__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

**Part 2 – To Be Completed by Employee’s Physician**

Dear Medical Provider,

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

The person named above should not receive the COVID-19 vaccine due to:

__________________________________________________________________________________________
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This exemption should be:

_____ Temporary, expiring on: __/__/____, or when ______________________________.

_____ Permanent

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): ______________________________________ Date: ___________________

Medical Provider Signature: ______________________________________

Practice Name & Address: ____________________________________________

Medical Provider Phone: _________________________

HR USE ONLY

Date Accommodation Request received: __________________________

Date Approved: __________________

Describe specific accommodation details:

______________________________________________________________

Date Denied: __________________

Describe why accommodation is denied:

______________________________________________________________

Employee Relations Representative Signature: __________________________ Date: _________________