UNIVERSITY OF WYOMING
DEPARTMENT OF HUMAN RESOURCES
Dept. 3422
1000 E.
University Ave.
Laramie, WY
82071

MEDICAL EXEMPTION TO MANDATORY COVID-19 IMMUNIZATION REQUIREMENT – UNIVERSITY OF WYOMING CLINICS

Instructions: Individuals who are requesting an exemption from the COVID-19 vaccine requirement due to a medical contraindication at the University of Wyoming Speech and Hearing Clinic, EHCW (Albany Community Health Clinic, UW Family Medicine Clinics at Casper and Cheyenne) the University of Wyoming Student Health Services and the Student Health Pharmacy should complete this form and return the completed form to the Department of Human Resources.

Requestor Information

Name:_____

Clinic:_____

Date of Submission:_____

Address:_____

Email:_____

Please identify your status:
☐ **Student** ☐ **Medical Staff** ☐ **Volunteer** ☐ **External Contracted Medical Provider** ☐ **Vendor**

I certify that I am requesting a waiver to the mandatory COVID-19 vaccine due to the existence of a medical contraindication. I understand that if an outbreak of this illness occurs at my place of employment or on UW campus, employees with a medical exemption may be excluded from campus for the duration of the outbreak or required to take other measures as determined by University officials**.**

Signature: _____ Date: _____

REQUIRES THE BELOW DOCUMENTATION AND THE SIGNATURE OF A MEDICAL PROVIDER

I recommend that the above-named employee be exempt from the COVID-19 immunization requirement due to the following medical contraindication as detailed by the CDC:

Please check box:

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

☐ Immediate allergic reaction of any severity to a previous dose or known (diagnosed) allergy to a component of the vaccine

☐ I hereby attest that this individual should delay receipt of COVID vaccination due to the following:

Reason:

_____

_____

_____

This contraindication applies to the following authorized COVID-19 vaccines:

_____

_____

___

Signature: _____ Date: _____

Name of Medical Provider (MD, DO or NP Only): _____ Date