University of California Medical Exemption Request Form

BERKELEY • DAVIS • IRVINE • LOS ANGELES • MERCED • RIVERSIDE • SAN DIEGO • SAN FRANCISCO

SANTA BARBARA • SANTA CRUZ

Name of Patient: ____________________

Status: ☐ Faculty ☐ Staff

Date of Birth: ____________________ MRN: ____________________

Name of Health Care Provider: ____________________

License Number: ____________________ Expiration Date: ____________________

State of Issuance: ____________________

License Type: ☐ Medical or Osteopathic Physician ☐ Nurse Practitioner ☐ Physician's Assistant

Practice Address: ____________________

Email: ____________________ Phone: ____________________

I hereby certify that the above-referenced patient qualifies for a medical exemption from influenza vaccine, as further provided below:

Reason for Exemption:

☐ CDC Contraindication ☐ CDC Precaution ☐ Manufacturer's Insert Contraindication ☐ Other

Provide a detailed explanation here regardless of the reason indicated immediately above:

____

This contraindication or precaution is: ☐ Permanent ☐ Temporary

- If temporary, the expiration date for the exemption is: ____________________

Signature of Health Care Provider: ____________________

Date of Signature: ____________________

Completed forms should be emailed to 15102952826@efaxds.com from your Berkeley email address, faxed to Occupational Health at (510) 642-6428, or uploaded to the Medical Exemption Documents Upload Form. *If you are unable to submit the form, call Occupational Health at (510) 642-6891.*

For Official Use Only:

☐ Approved ☐ Denied Date: ____________________

Name: ____________________ Title: ____________________

Signature: ____________________

UC Location: ____________________