

## Student Request for Medical Exemption from COVID-19 Vaccination Form

Name: \_\_\_\_\_  
Student ID: \_\_\_\_\_ College Email: \_\_\_\_\_ Phone: \_\_\_\_\_

Maine Community College System policy requires that all students provide proof of a COVID-19 vaccination before attending in-person classes or residing in campus housing, as communicated via this web page: <https://www.mccs.me.edu/covid-19/vaccine-protocol/>. A medical exemption from this requirement may be requested by submitting medical documentation signed and certified by a licensed physician, nurse practitioner or physician assistant, who is not related to and is otherwise independent from the student, and whose practice area is appropriate to the medical condition or documented disability for which the exemption is requested. Students seeking an exemption may not attend in-person classes or move into campus housing until the exemption is approved.

Individuals with an approved exemption may be required to make preventive measures as specified in the exemption approval, and as may be outlined by later notification and/or posting of requirements on the WCCC COVID information website.

In the event of a COVID outbreak on or near campus, individuals holding exemptions may be subject to additional restrictions, up to and including physical exclusion from campus facilities and in-person programs, until the outbreak is declared to be over.

The Accessibilities Specialist or designee will review all exemption requests. After a request has been reviewed and processed, students will be notified via their college email address of the decision on their request. Exemptions approved for temporary medical conditions will expire when the medical condition(s) contraindicating vaccination changes in a manner which permits vaccination.

Decisions on medical exemptions from the COVID-19 vaccination may be appealed to the Dean of Enrollment Management and Student Services in accordance with the college's appeal process for disability accommodations. In addition, students may reapply if new documentation and information supporting the request becomes available. In order to submit a request, please:

- Read the CDC COVID-19 Vaccine Information at <https://www.cdc.gov/coronavirus/2019-ncov/vaccines/keythingstoknow.html>
- Complete this form
- Have your licensed physician, nurse practitioner or physician assistant complete the provider section of this form and attach the required documentation.

- Submit the completed documents to [accessibility@wccc.me.edu](mailto:accessibility@wccc.me.edu) or One College Drive, Calais, ME 04619. **Note:** Incomplete submissions will not be reviewed and will be returned.
- Initial each of the following statements:

	I acknowledge that I have read the CDC COVID-19 Vaccine Information.
	I understand and assume the risks of non-vaccination during the COVID-19 pandemic.
	I understand and agree to comply with and abide by all WCCC and Maine Community College System COVID-19 policies and procedures, including COVID-19 face covering requirements and other mitigation measures that may be imposed, and with guidance issued by WCCC and the Maine Community College System.
	I understand that in the event of an outbreak on campus, I may be subject to additional mitigation measures, up to and including temporary physical exclusion from facilities and sponsored activities.
	In the event I contract COVID-19 or am a close contact with a person believed or known to be infected with COVID-19, I will immediately report it to the College (via email to <a href="mailto:ncote@wccc.me.edu">ncote@wccc.me.edu</a> ) and follow the CDC guidelines for those who are infected or a close contact, including any required isolation or quarantine period.
	I authorize my licensed health care provider to provide WCCC with my medical information necessary to support my request for a medical exemption from immunization against COVID-19, including in response to any questions that WCCC may have for the purpose of evaluating my request.
	I certify that the information I have provided in support of this request is accurate and complete as of the date of this submission.
	I understand an approved exemption may be revoked and I may be subject to disciplinary action if any false information is submitted in support of my request for a medical exemption.
	I understand that an approved exemption will expire if/when the medical condition(s) contraindicating vaccination changes in a manner which permits vaccination.

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_

ID: \_\_\_\_\_ College Email: \_\_\_\_\_

Phone Number: \_\_\_\_\_

By checking this box and typing my name above, I understand and agree that I am submitting this document electronically and that it is the legal equivalent of placing my handwritten signature on the submitted document.                      Date: \_\_\_\_\_

**TO BE COMPLETED BY LICENSED PHYSICIAN, NURSE PRACTITIONER OR PHYSICIAN ASSISTANT**

The Maine Community College System requires that all students receive a COVID-19 vaccination before attending live, in-person classes. \_\_\_\_\_ (insert patient's name) is requesting a medical exemption from this vaccination requirement.

On your professional letterhead, please explain in detail the medical condition or documented disability that you believe should exempt your patient from immunization against COVID-19, the medical basis for your professional opinion that the medical condition/disability should qualify for an exemption, the date on the onset of the condition/disability, and if applicable, the probable duration of the medical condition/disability. If applicable, please reference CDC guidance that supports an exemption for your patient's condition.

**Certification:**

I certify that the attached signed and dated documentation is true and correct and that in my professional judgment it is medically inadvisable for this individual to be immunized against COVID-19 for the reasons provided.

**Provider Information:**

Medical Provider Name: \_\_\_\_\_

Medical Provider Specialty/Area of Practice: \_\_\_\_\_

Signature: \_\_\_\_\_

Provider License Type and Number: \_\_\_\_\_

Date: \_\_\_\_\_

Address: \_\_\_\_\_

Email: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Name of Provider's Employer: \_\_\_\_\_

Employer Contact Information (if different from above): \_\_\_\_\_

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