The College of New Jersey
COVID-19 VACCINE MEDICAL EXEMPTION FORM

Name of Employee:	Date of Birth	Employee ID#

To be completed by a physician licensed to practice medicine or osteopathy, or an advanced practice nurse, in any jurisdiction of the U.S., or in any foreign country:

The employee named above is subject to a mandatory COVID-19 vaccination requirement. The above-named employee is requesting a medical exemption from this vaccination requirement. A medical exemption may be granted when a physician licensed to practice medicine or osteopathy, or an advanced practice nurse, in any jurisdiction of the U.S., or in any foreign country, indicates that COVID-19 vaccine is medically contraindicated for a specific period of time and providing the reason(s) for the medical contraindication. Contraindications and precautions to COVID-19 vaccines can be found on the CDC webpage, https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html#Contraindications. Please review this webpage to ensure that you have the most recent CDC contraindications and precautions to COVID-19 vaccines. This completed form may be returned to the employee.

Exemption Length	CDC Contraindication
☐ Temporary through: ____/____/_____ ☐ Permanent	☐ 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. The list of COVID-19 vaccine components can be found in Appendix C of the CDC Interim Clinical Consideration for Use of COVID-19 Vaccines Currently Authorized in the U.S. at https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html.

Exemption Length	CDC Precaution
☐ Temporary through: ____/____/_____ ☐ Permanent	Precautions to COVID-19 vaccination can be found on the CDC webpage, https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html#Contraindications. ☐ The physical condition of the employee or medical circumstances relating to the employee are such that COVID-19 is not considered safe. Please indicate in the space below or in a separate narrative attachment the specific nature of the medical condition or circumstances that contraindicate immunization with the COVID-19 vaccine.

Attestation

By signing below, I affirm that I have reviewed the current CDC Contraindications and Precautions for COVID-19 Vaccinations. I understand that I might be required to submit supporting medical documentation.

Healthcare Provider Name (please print): _____ Specialty: _____

NPI Number: _____ License Number: _____ State of Licensure: _____

Phone: _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Signature: _____ Date: _____