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: ☐ Student ☐ Faculty/Academic Personnel ☐ Staff/Other Employee

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 the 2020-2021 seasonal influenza vaccine, as further provided below:

Reason for Exemption:

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

This contraindication or precaution is: ☐ Permanent ☐ Temporary

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

Signature of Health Care Provider: ______________________________

Date of Signature: ______________________________

Students: Return this completed form to your Student Health Service.
Faculty and Staff: Return this completed form to your campus-Authorized Official.

For Official Use Only:

☐ Approved ☐ Denied Date: ______________________________

Name: ______________________ Title: ______________________

Signature: ______________________________

UC Location: <Choose One>______________________________