STUDENT COVID-19 VACCINATION MEDICAL EXEMPTION FORM

Student Name: __________________________ SID: __________ Phone: __________

A medical exemption must be based on documentation from a licensed health care provider confirming that the student is medically unable to receive an authorized COVID-19 vaccine. The documentation must also include a duration the accommodation will be needed. For the purposes of this medical exemption request, a health care provider includes all qualified and licensed MD, ND, DO, ARNP, or PA professionals.

If you have any questions, please contact the DSS Office at dss@columbabasin.edu or 509-544-2032.

THIS SECTION MUST BE COMPLETED BY YOUR LICENSED HEALTH CARE PROVIDER.

Health Care Provider Name & Credential: __________________________

(Must be MD, DO, ARNP, or PA)

Health Care Provider License Number & State: __________________________

Health Care Provider Address: ______________________________________

Health Provider Phone: __________________________

1. What is your area of practice or medical expertise? __________________________

2. Please identify the condition that prevents your patient named above from receiving an authorized COVID-19 vaccine: __________________________

   __________________________
   __________________________
   __________________________

3. Please state the anticipated duration of the medical condition stated above which prevents your patient from receiving an authorized COVID-19 vaccination: __________________________

   __________________________
   __________________________

I declare that in my professional opinion, the above information is true and accurate to the best of my knowledge and ability.

Health Care Provider Signature: __________________________ Date: __________

Upload, fax, or mail this completed and signed form to Disability Support Services

Fax: 509-544-2032
Mail: 2600 N. 20th Avenue, Mail Stop T-7, Pasco, WA 99301