WRIGHT STATE UNIVERSITY

Health Management Initiative Program

COVID-19 Vaccine Exemption Request
Medical Information Form

Office of Disability Services
3640 Colonel Glenn Hwy.
Dayton, OH 45435-0001
(937) 775-5680
TTY (937) 775-5844
Fax: (937) 7755699
Email: ada@wright.edu
wright.edu/disability-services

The Office of Disability Services (ODS) at Wright State University coordinates reasonable accommodations for employees with diagnosed and qualifying disabilities in accordance with the Americans with Disabilities Act, as amended. In doing so, ODS staff enter an interactive process in order to implement the most appropriate accommodation strategies. As part of the interactive process, ODS seeks input from the employee's licensed medical provider. The licensed medical provider completing this form should be licensed in the field of expertise to make the diagnosis.

The Office of Disability Services will keep this information confidential. Please feel free to contact the Office of Disability Services with any questions or concerns you might have regarding the information you are being asked to provide.

PART ONE: RELEASE OF INFORMATION AUTHORIZATION (TO BE COMPLETED BY THE EMPLOYEE)

For the purpose of establishing eligibility for accommodations and services, the Office of Disability Services will ask for documentation of your medical condition. Please sign below, indicating you have given the licensed medical provider below permission to release specific medical information that directly relates to the functional impact of your disability on receiving the COVID-19 vaccination, to the Office of Disability Services at Wright State University.

Employee Name (Printed)	**Signature**	**Date**

PART TWO: EMPLOYEE NAME AND MEDICAL CONDITION INFORMATION (TO BE COMPLETED BY LICENSED MEDICAL PROVIDER)

Employee's Name	Date of Last Contact with Employee

Please describe the employee's health-related contraindication that is related to the request for a COVID-19 vaccine exemption. Approximately when was the medical condition or contraindication diagnosed?

Please describe the employee's risk for allergic reaction to an ingredient in the COVID-19 vaccine.

Please describe the employee's history of allergic reactions to other vaccines or other medical injections.

LICENSED MEDICAL PROVIDER INFORMATION (TO BE COMPLETED BY LICENSED MEDICAL PROVIDER)

Name and Title (Printed)

Signature

Professional License Number

Date

Medical Provider Office Address and Phone Number

Please mail or fax this form using the contact information below. For privacy purposes, please do not email this form.

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180 University Hall
Dayton, OH 45435-0001
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