ANNE ARUNDEL COMMUNITY COLLEGE
101 College Parkway | Arnold, Maryland 21012-1895 | 410-777-AACC (2222) | www.aacc.edu

Clinical Employee Medical Certification for Request for Accommodation from COVID-19 Vaccination Requirement for Disability or Medical Reasons

To be completed by medical provider for the following individual:

Employee Name: _____

Dear Medical Provider,

As part of our commitment to the health and safety of Anne Arundel Community College ("College") employees, students, the greater community, and patients and employees at our clinical site affiliates, all employees and students participating in clinicals, fieldwork, externships or internships in a health care or clinic setting within the School of Health Sciences or the School of Continuing Education and Workforce Development ("Clinicals") will be required to be fully vaccinated against COVID-19 with a vaccine fully approved or approved for emergency use authorization by the Food & Drug Administration or by the government of a foreign country where the vaccine was administered ("COVID-19 vaccine"), beginning with the Spring, 2022 semester. Testing will be not permitted in lieu of vaccination for individuals participating in Clinicals, unless the individual has requested and been granted an accommodation.

The individual named above, a College Employee ("Employee"), is seeking an accommodation from this protocol due to a disability or medical reasons. If, in your medical opinion, you believe that the Employee should not receive a COVID-19 vaccination, please complete this form to assist College in the reasonable accommodation process.

1. Please explain the nature of the Employee's medical condition(s) or disability and how you believe this medical condition(s) or disability prevents the Employee from getting a COVID-19 vaccine.

2. If the Employee is allergic to a COVID-19 vaccine, please select all that apply:
   - □ The Employee had a severe anaphylactic reaction to a prior dose of one of the mRNA COVID-19 vaccines that required the use of epinephrine or EpiPen
     - o Date of reaction _____
     - o Allergic to (check all that apply): ___ Pfizer
       ___ Moderna
       ___ J&J
       ___ Other _____
   - □ The Employee has an allergy to a component of the vaccine
     - o Vaccine component(s) the Employee is allergic to _____
     - o Date of diagnosis of allergy _____

- Allergic to (check all that apply): ___ Pfizer
  ___ Moderna
  ___ J&J
  ___ Other _____

3. If you believe that the Employee's physical condition or medical circumstances are such that immunization is not considered safe, please indicate the specific nature and probable duration of the medical condition or circumstances that contraindicate immunization with the COVID-19 vaccine in the box below. Otherwise, input N/A.

   - Date of diagnosis of medical condition: _____
   - Contraindication for (check all that apply): ___ Pfizer
     ___ Moderna
     ___ J&J
     ___ Other _____

4. If the Employee seeking a medical deferral for any of the following reasons, please select all that apply:

   □ The Employee tested positive for COVID-19 within the last 90 days
   - Date of positive test _____

   □ The Employee been treated with monoclonal antibodies within the last 90 days
   - Date of last treatment with monoclonal antibodies _____
   - Date treatment with monoclonal antibodies will end* _____
     *If you do not have an anticipated date when treatment will end, input "Unknown"

   □ The Employee been treated with convalescent plasma within the last 90 days
   - Date of last treatment with convalescent plasma _____
   - Date treatment with convalescent plasma will end* _____
     *If you do not have an anticipated date when treatment will end, input "Unknown"

   □ The Employee has a history of multisystem inflammatory syndrome (MIS-A or MIS-C)
   - Date of diagnosis _____

   □ The Employee is currently taking medication that suppresses the immune system
   - Name of medication _____
   - Date medication was last taken _____
   - Date treatment will medication will end* _____
     *If you do not have an anticipated date when treatment will end, input "Unknown"

5. Please state the accommodation that is being requested.

6. Please state the length of time for which this accommodation is requested.

I certify that the Employee has the above referenced medical conditions and request accommodation for the Employee not to receive the COVID-19 vaccination.

Medical Provider Name (print):_____

Medical Provider Signature:_____

Date: _____

Medical Name and Practice Address: _____

_____

Medical Practice Phone Number: _____