COVID-19 Vaccination Requirement
Temporary Medical Accommodation Request Form

To request a temporary medical accommodation from the SUNY COVID-19 Vaccination requirement, please complete this form and submit it to The Accommodative Services Office, CLC 15-137E or accommodations@sunyjefferson.edu . A decision regarding your request will be released through an email from the College.

Part I. Student Information and Certification:

LAST NAME	FIRST NAME	STUDENT EMAIL ADDRESS	DATE OF BIRTH	STUDENT ID #

Please check each box to acknowledge:

☐ While my request is pending, I understand that I must comply with the campus' COVID-19 related health and safety protocols (e.g., masks/face coverings, social distancing, regular surveillance testing) applicable to unvaccinated or partially vaccinated individuals as a condition of my physical presence in a SUNY Facility.

☐ I certify that I have confirmed with my academic program that not receiving the COVID-19 Vaccination will not prevent the completion of my programmatic or curricular requirements.

☐ If my request is granted, I understand that I will be required to comply with the campus' COVID-19 related health and safety protocols (e.g., mask/face coverings, social distancing, regular surveillance testing) if accessing a SUNY Facility as a condition of my on-going physical presence. I am aware that should a COVID-19 outbreak occur at the campus that I may be excluded from all in-person classes and activities and that if I am enrolled in courses that require a physical presence on campus that I may not be able to complete my academic coursework remotely. I acknowledge that any refund I might be entitled to in the case of a COVID-19 outbreak would be subject to all existing SUNY policies.

☐ I understand that this exemption only applies to **Jefferson Community College Campus**. If I attend any off site classes, clinicals, labs, internships etc. I will have to follow the sites rules for Covid vaccination and go through their process separately from Jefferson's.

Signature*: _____ Date: _____
*Student, but Parent or Legal Guardian must sign if the student is under 18 years old as of first day of classes.

Please note that the campus reserves the right to request additional documentation to support a request for a medical exemption.

Part II. Partial COVID-19 Vaccination in Process

If you are in the process of receiving your COVID-19 vaccination and you will not make the September 27th deadline please complete this section.

Please select which of the following vaccination processes you are in:

☐ I have received the first dose of the COVID-19 vaccination. (Please include a copy of your card)

Date:_____ ☐Moderna ☐Pfizer ☐Johnson & Johnson

☐ I have a scheduled appointment for my first does of the COVID vaccine. Please include a copy of your appointment confirmation. You will need to submit a copy of your vaccination card within 48 hours of the first dose.

Date:_____ Time: _____ Location:_____

☐Moderna ☐Pfizer ☐Johnson & Johnson

Part III. Temporary Medical Accommodation due to COVID-19 positive diagnosis

If you have tested positive with COVID-19 and would like to request a 90 day extension to receive the vaccine or booster shot please complete this section. You will need to include a copy of your:

*positive test results
*public health isolation order
*public health release order

Please select which of the following vaccination processes you are in:

☐ I have completed the initial vaccination series. (Please include a copy of your card)

Dates:_____ ☐Moderna ☐Pfizer ☐Johnson & Johnson

☐ I am requesting an extension for the next step in the vaccination series. (Please include a copy of your card)

☐ Second dose ☐ Booster dose

Date:_____ ☐Moderna ☐Pfizer ☐Johnson & Johnson

Please note: if approved, the 90 days will start the day that you are released from the public health order.

Part IV. Temporary Medical Accommodation (to be completed by medical provider)

A licensed medical provider (Physician, Physician's Assistant, or Nurse Practitioner) and student should review the CDC guidance regarding the COVID-19 vaccines. The provider must complete Section(s) A and/or B and provide their provider information in Section C.

Section A. Medical Provider Certification of Temporary Medical Accommodation: I certify that my patient (named above) cannot be vaccinated currently from COVID-19 because of the following :

Please select which of the temporary medical accommodation is requested by receiving the COVID-19 vaccine apply:

☐ Severe allergic reaction due to a current medication/experimental treatment.

☐ Immediate allergic reaction to previous dose or known (diagnosed) allergy to a component of the vaccine. (***Describe reaction/response below and contraindication to alternative vaccines***).

☐ Physical condition/medical circumstance that vaccination would not be considered safe. (***Describe condition/circumstance below and contraindication to alternative vaccines***).

☐ Other. (***Describe in detail and your profressional opinion why this individual should be exempt from vaccination***).

Additional details on the selected option(s) above (to be completed by the medical provider):

_____

_____

_____

Clinician Certification: **By completing this form, you certify that the patient named above should receive a temporary medical accommodation for the COVID-19 vaccination.**

Section B. Medical Provider Certification of Disability That Makes COVID-19 Vaccination Temporarily Inadvisable

"Disability" is defined as any impairment resulting from anatomical, physiological, genetic, or neurological conditions which prevents the exercise of a normal bodily function or is demonstrable by medically accepted clinical or laboratory diagnostic techniques and any other condition recognized as a disability under applicable law.

"Disability" may include pregnancy, childbirth, or a related medical condition where reasonable accommodation is medically advisable.

I certify that my patient (named above) has the following disability that makes COVID-19 Vaccination inadvisable: _____

Additional details on why the disability listed above makes COVID-19 Vaccination Inadvisable (to be completed by the medical provider):

_____

_____

_____

_____

_____

Being temporary, the expected end date is: _____

Section C. Medical Provider Information

Provider Name: _____

Provider National Provider Identifier (NPI): _____

Provider Specialty: _____

Provider Employer/Affiliation: _____

Provider Phone: _____ Fax: _____

Provider Address: _____

Provider Email: _____

Provider Signature: _____ Date of signature: _____