COLLEGE OF MARIN

Department of Human Resources

MAILING ADDRESS
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FORM INSTRUCTIONS

Please have your physician complete this form and request and submit all related medical Documentation. Self-completed forms will not be accepted. **Accordingly, the District asks that you please complete and return the enclosed questionnaire within 7 days of receipt**.

TO BE COMPLETED BY YOUR PHYSICIAN

Dear Physician:

In order to promote a safe and healthy work and academic environment, Marin Community College District has set forth directives and policies regarding COVID-19 and COVID-19 vaccination status. A medical exemption from COVID-19 vaccination is allowed for certain recognized contraindications. Please complete the following:

Patient/Employee's Name: _____

The individual listed above should not be immunized for COVID-19 for the following reasons (Please check all that apply):

Allergy

☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a component of the COVID-19 vaccine

☐ Immediate allergic reaction of any severity to a previous dose or known (diagnosed) allergy to a component of the vaccine (Vaccine Ingredients: https://www.cdc.gov/vaccines/covid-19/info-by-product/index.html)

Which ingredient caused an allergic reaction? _____

What was the reaction? _____

Which brand of the COVID-19 vaccine is contraindicated and why? _____

_____

How long will the medical contraindication last? _____

Physical Condition/Medical Circumstance

☐ Other Medical Limitation – Please provide this information in a separate narrative that describes the other medical limitation requiring an exemption.

_____

_____

Physician Certification

I certify that _____ has the above contraindication and I recommend that he/she should not take the COVID-19 vaccine until _____.

Physician Signature:_____ Date:_____

(Note: Signature Stamp Not Acceptable)

Physician Medical License No.: _____