WOFFORD COLLEGE

Faculty and Staff Exemption Request Form

Name _____
First Last Middle Initial

Signature _____ Date _____
Employee signature. I attest the following to be accurate and true.

Section II: Medical Exemption Request (to be completed by medical provider)

Medical Provider Certification of Contraindication: I certify that my patient (named above) should not be vaccinated against COVID-19 because the patient has one of the following contraindications:

☐ Documented anaphylactic allergic reaction or other severe adverse reaction to any COVID-19 vaccine (For example, cardiovascular changes, respiratory distress or history of treatment with epinephrine or other emergency medical attention to control symptoms. This, generally, does not include gastro-intestinal symptoms as the sole presentation of allergy.) Describe the specific reaction:
_____
_____

☐ Documented allergy to a component of the vaccine; does not include sore arm, local reaction or subsequent respiratory tract infection. Describe the specific reaction:
_____
_____

☐ Another documented contraindication. (Information to be reviewed by infectious disease consultants for approval.) Please explain: _____
_____

Healthcare Provider (please print) _____

Address/Clinic Stamp _____

Signature _____

Phone _____

Once completed, return to the Office of Human Resources.

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Section III: Religious Beliefs Exemption Request

The Religious Exemption form should be used by those who in the past have NOT been vaccinated due to religious beliefs. Requests for exemption based on religious beliefs: if the bona fide religious beliefs of an individual is contrary to the immunization requirement for a COVID-19 vaccine, the individual will be exempt of the requirement upon submission of a written statement below of the bona fide religious beliefs and opposition to the immunization requirement.

Statement:

_____

_____

_____

_____

_____

_____

_____

Signature _____ Date _____

Once completed, return this form to the Office of Human Resources.