

Instructions for ETSU Faculty or Staff reviewing the following form:

**DOCUMENTATION OF MEDICAL OR RELIGIOUS EXEMPTION
TO A CLINICAL AFFILIATE VACCINE REQUIREMENT**

Medical Exemption:

1. Ensure the entire section is complete.
2. Ensure a healthcare provider has signed the appropriate line.
3. Sign your name on the line "Reviewed by."
4. Process the form.

Religious Exemption:

1. Ensure the entire section is complete.
2. Sign your name on the line "Reviewed by."
3. Process the form.

In reviewing this form if you have any question or concern about the form's legitimacy please call the Office of University Counsel.

This form is confidential. This form should be used for its intended purpose and should be stored in a manner that restricts access to those who access is necessary to fulfill their job duties as assigned.

**DOCUMENTATION OF MEDICAL OR RELIGIOUS EXEMPTION
TO A CLINICAL AFFILIATE VACCINE REQUIREMENT**

Clinical Affiliates may require vaccinations prior to granting access to their facilities. This form should be completed by East Tennessee State University Faculty or Students requesting a medical or religious exemption to a Clinical Affiliate's vaccine requirement. Please complete the appropriate section.

Faculty/Student

Printed Name: _____

E#: _____

REQUEST FOR MEDICAL EXEMPTION FROM VACCINATION

If you are requesting a medical exemption from vaccination please have your healthcare provider complete this section. Please note that your presence in a clinical setting may increase your risk of exposure to disease.

Note: This section must be completed by your healthcare provider.

The below vaccination(s) is/are medically contraindicated for the above-named individual:

Hepatitis B: ___ Flu (Influenza): ___ MMR: ___ Varicella: ___ Meningococcal: ___ Tdap ___

Meningococcal: ___ Tdap ___ COVID-19: ___

Other (print vaccine name): _____

Other (print vaccine name): _____

Other (print vaccine name): _____

Reason for Exemption:

_____.

This contraindication is permanent _____; or temporary _____; and is expected to preclude immunization until: Date (Mo/Day/Yr) ____/____/_____.

Signature of Provider: _____ Date: ____/____/____

Printed Name of Provider: _____ License #: _____

Office Address: _____

Office Telephone: _____

REQUEST FOR RELIGIOUS EXEMPTION FROM VACCINATION

If you are requesting a religious exemption from vaccination please complete this section.

The below required vaccination(s) conflict with my sincerely held religious beliefs and practices:

Hepatitis B: ___ Flu (Influenza): ___ MMR: ___ Varicella: ___ Meningococcal: ___ Tdap ___

Meningococcal: ___ Tdap ___ COVID-19: ___

Other (print vaccine name): _____

Other (print vaccine name): _____

Other (print vaccine name): _____

I certify and affirm that the administration of the immunization(s) listed above conflict(s) with my religious tenets or beliefs. I declare (or certify, verify, or state) **under penalty of perjury** under the laws of the United States of America that the foregoing is true and correct.

Signature of Faculty/Student: _____ Date: ___/___/___

Reviewed by: _____ **Date:** ___/___/___