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

Medical Certification for Request for Accommodation from COVID-19 Vaccination and Testing

To be completed by medical provider for the following individual:

Employee Name: _____

Dear Medical Provider,

Anne Arundel Community College ("College") requires vaccination 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") or testing for COVID-19 ("COVID-19 testing") for employees who physically enter the workplace as a condition of employment. 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 and should not be tested for COVID-19, please complete this form to assist College in the reasonable accommodation process.

Vaccination:

The Employee should not be immunized for COVID-19 for the following reasons (please check all that apply):

☐ The Employee has a history of previous allergic reaction to indicate an immediate hypersensitivity reaction to a component of the vaccine.

Please indicate the type of prior allergic reaction, the component of the vaccine at issue, and the reason it indicates a hypersensitivity to a component of the vaccine.

Date of diagnosis of allergy: _____

☐ 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.

Date of diagnosis of medical condition: _____

☐ Other

Please provide a narrative that describes the reasons the Employee needs an accommodation from the COVID-19 vaccine option.

Date of diagnosis of medical condition: _____

State which brand(s) of the COVID-19 vaccine is contraindicated:
___ Johnson & Johnson
___ Moderna
___ Pfizer
___ Other (please indicate the name of the vaccine that is contraindicated) _____

Testing:

The Employee should not be tested for COVID-19 for the following reasons (please check all that apply):

The Employee's physical condition or medical circumstances are such that testing is not considered safe.

Please indicate the specific nature and probable duration of the medical condition or circumstances that contraindicate testing for COVID-19 in the box below, including whether the Employee could be tested using certain testing techniques but not others (*e.g.*, nasal swab, saliva, etc.).

Date of diagnosis of medical condition: _____

☐ Other

Please provide a narrative that describes the reasons the Employee needs an accommodation from the COVID-19 testing option in the box below.

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Date of diagnosis of medical condition: _____

Accommodation Request:

Please state the accommodation that is being requested.

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

I certify that the Employee has the above referenced medical conditions and request accommodation from both COVID-19 vaccination and testing for the Employee.

Medical Provider Name (print):_____

Medical Provider Signature:_____ Date: _____

Medical Practice Name and Address: _____
_____

Practice Telephone: _____