Illinois Wesleyan University

Request for Medical Exemption from COVID-19 Vaccination

To request an exemption from the state-mandated COVID-19 vaccination, please complete section 1 below and have your medical provider complete section 2 before returning this form to the Human Resources office.

Individuals with an approved exemption will be required to comply with COVID-19 testing and other preventative requirements as stated by the University. Failure to do so may result in disciplinary action, up to and including termination.

Section 1

Name (print):	Date:
Dept.:	Work/Cell Phone:

I am requesting a medical exemption from Illinois Wesleyan University's mandatory vaccination policy for COVID-19 vaccination for the following reason:

I verify that the information I am submitting to substantiate my request for exemption from the Illinois Wesleyan University's vaccination policy is true and accurate to the best of my knowledge. I understand that any falsified information can lead to disciplinary action, up to and including termination.

I further understand that Illinois Wesleyan University is not required to provide this exemption if doing so would pose a direct threat to myself or others in the workplace or would create an undue hardship for the University.

Employee Signature:	Date:

Section 2

Medical Certification for Vaccination Exemption

Employee Name: _____

Dear Medical Provider,

Per state mandate, Illinois Wesleyan University requires vaccination against COVID-19 as a condition of employment. The individual named above is seeking an exemption to this policy due to medical contraindications.

Please complete this form to assist Illinois Wesleyan University in the reasonable accommodation process.

The person named above should not receive the COVID-19 vaccine due to:
This exemption should be: ☐ Temporary, expiring on: __/__/____, or when _____ ☐ Permanent

I certify the above information to be true and accurate, and request exemption from the COVID-19 vaccination for the above-named individual.

Medical Provider Name (print):	
Medical Provider Signature:	Date:
Practice Name & Address:	Provider Phone:

HR USE ONLY

Date of initial request: __/__/____ Date certification received: __/__/____

Accommodation request:

☐ Approved __/__/____
Describe specific accommodation details:

Individuals with an approved exemption will be required to comply with COVID-19 testing and other preventative requirements as stated by the University.

_____

☐ Denied __/__/____
Describe why accommodation is denied:

_____