REQUEST FOR A MEDICAL EXEMPTION OR DELAY TO THE COVID-19 VACCINATION REQUIREMENT

OMB No. 0704-0619
Exp. 20220430

PRIVACY ACT STATEMENT

Authority: DoD is authorized to collect the information on this form pursuant to 29 U.S.C. 794, 42 U.S.C. Chapter 21, Subch. VI; Executive Order (E.O.) 14043, Requiring Coronavirus Disease 2019 Vaccination for Federal Employees; E.O. 13163, Increasing the Opportunities for Individuals with Disabilities to be Employed in the Federal Government; E.O. 13164, Requiring Federal Agencies to Establish Procedures to Facilitate the Provision of Reasonable Accommodation; 29 CFR 1614.203, Rehabilitation Act; DoD Directive 1020.1, Nondiscrimination on the Basis of Handicap in Programs and Activities Assisted or Conducted by the Department of Defense; as well as 10 U.S.C. 113, 10 U.S.C. 136, 10 U.S.C. 7013, 10 U.S.C. 8013, 10 U.S.C. 9013, 10 U.S.C. 2672, 5 U.S.C. chapter 79, and DoD Instruction 6200.03.

Principal Purpose: The information on this form is being collected so that DoD may determine whether to grant your request for a medical exemption from the COVID-19 vaccination requirement for federal employees, pursuant to Executive Order 14043 and in furtherance of COVID-19 workplace safety plans.

Routine Use(s): While the information requested on this form is intended to be used primarily for internal purposes, in certain circumstances it may be necessary to disclose this information externally. For example, disclosure of medical condition or history information to authorized government officials for the purpose of conducting an investigation into DoD's compliance with the Rehabilitation Act of 1973; disclosure of medical condition or history information to first aid and safety personnel in the event an employee's medical condition might require emergency treatment or special procedures; to Federal agencies/entities participating in the DoD Computer/Electronic Accommodations Program (CAP) to permit the agency to carry out its responsibilities under the program; A complete list of routine uses may be found in the applicable System of Records Notice (SORN) associated with the collection of this information: DoD 0007, Defense Reasonable Accommodations and Assistive Technology Records, 86 Fed. Reg. 38692 (July. 22, 2010) (available at **https://www.govinfo.gov/content/pkg/FR-2021-07-22/pdf/2021-15601.pdf**).

Consequences of Failure to Provide Information: Providing this information is voluntary and use of this form is optional. Failure to provide the information requested on this form may impact DoD's ability to evaluate or act upon a request for a medical exemption from the COVID-19 vaccination requirement. Any intentional misrepresentation to the Federal Government may result in legal consequences, including termination or removal from Federal Service.

Instructions: Part 1 is to be completed by DoD civilian employees. Part 2 is to be completed by a licensed health care provider. Provide narrative responses where applicable (Blocks 8-10, 15-17). If additional space is needed, proceed on the appropriate continuation block (Block 11 or 20) by annotating the Section and Line number and continue your narrative response. Signing this form constitutes a declaration that the information you provide is, to the best of your knowledge and ability, true and correct. Any intentional misrepresentation to the Federal Government may result in legal consequences, including removal from Federal Service.

PART 1. TO BE COMPLETED BY THE DOD CIVILIAN EMPLOYEE

1. Employee Name *(Last, First, Middle Initial)*		2. DoD ID Number
3. Office Symbol		4. Date of Request *(YYYYMMDD)*
5. Position/Title	6. Supervisor Name	7. Supervisor Phone Number

8. Please provide a description of the medical condition or circumstance that is the basis for the request for a medical exemption from the COVID-19 vaccination requirement.

9. Please provide an explanation of why the medical condition or circumstance prevents you from being vaccinated.

10. Please provide any additional information, that addresses your particular medical condition or circumstance, which may be helpful in resolving your request for a medical exemption or delay from the COVID-19 vaccination requirement. If you have medical documentation (in addition to Part 2 of this Form) that addresses your particular medical condition or circumstance you may submit the documentation to your supervisor along with this form.

11. Continuation

I declare to the best of my knowledge and ability that the foregoing is true and correct.

12. Date *(YYYYMMDD)*	**13. Signature**

PART 2. COMPLETED BY EMPLOYEE'S HEALTH CARE PROVIDER

14. Employee Name

MEDICAL CERTIFICATION FOR COVID-19 VACCINE EXEMPTION OR DELAY

Dear Health Care Provider:

The Department of Defense requires its employees to be fully vaccinated against COVID-19, pursuant to Executive Order of the President of the United States. As indicated in Part 1, the individual named above is seeking a medical exemption to the requirement for COVID-19 vaccination or a delay because of a temporary condition or medical circumstance. Please complete this form to assist the Department in its review process.

Please provide at least the following information, where applicable, and use the continuation block as needed:

15. Please identify any contraindication(s) or precaution(s) for COVID-19 vaccination that are applicable to the individual, and for each contraindication or precaution, indicate:
(a) whether it is recognized by the U.S. Centers for Disease Control and Prevention pursuant to its guidance; and
(b) whether it is listed in the package insert or Emergency Use Authorization fact sheet for each of the COVID-19 vaccines authorized or approved for use in the United States.

16. Please provide a statement detailing how the individual's condition and medical circumstances are such that COVID-19 vaccination is not considered safe. Please explain the specific nature of the medical condition or circumstance that contraindicates immunization with a COVID-19 vaccine or might increase the risk for a serious adverse reaction.

17. Please provide any other medical information that would limit the employee from receiving any COVID-19 vaccine.

18. The condition described above is:

☐ Temporary

☐ Long-Term/Permanent

19. If the employee is seeking a delay due to a temporary medical condition or circumstance, please indicate when the employee would be able to safely receive a COVID-19 vaccination - provide details if limited to specific COVID-19 vaccine(s) or type(s) of COVID-19 vaccine.

20. Continuation

21. Health Care Provider Name/Title

22. Date *(YYYYMMDD)*	**23. Medical Provider Signature**