Roane State Community College
COVID-19 Medical Exemption Form for Clinical Partners

Please fill out this form to assist RSCC and our clinical partners with processing your request for a medical exemption from our clinical partners' COVID-19 vaccination. In addition, you may need to fill out forms required by our clinical partners. The information you supply will be used to help RSCC process your request in accordance with the requirements of our clinical partners' requirements and published CMS guidance. This form will be included in your student health file and may be shared with one or more of our clinical partners. If a student's request for medical exemption is not accepted by clinical partners, RSCC will do their best to obtain a clinical placement for the student. However, RSCC cannot guarantee such placements. **NOTE**: If you are seeking a temporary deferral of the COVID-19 vaccination requirement because you have been infected with the COVID-19 virus and/or received convalescent plasma or monoclonal antibodies within the past 90 days, please request a Medical Deferment Request Form.

Please review the attached "Summary Document for Interim Clinical Considerations for Use of COVID-19 Vaccines Currently Authorized or Approved in the United States" and share it with your certifying healthcare provider. You must submit the attached Healthcare Provider Certification as part of your request.

Please identify the qualifying medical condition that a medical provider considers a contraindication to the COVID-19 vaccine, consistent with CDC guidance (Use space below and additional sheet(s) as needed).

Please ensure your healthcare provider completes the attached Healthcare Provider Certification. This certification must be completed by a licensed practitioner, who is not the individual requesting the exemption and who is acting within the scope of their respective practice.

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

Signature: _____
PRINT NAME: _____
Date: _____

Date Request Received _____

Request Approved? Yes _____ No _____

Any conditions: _____

Reason for denial:

Signed: _____
RSCC Dean of Health Sciences

HEALTHCARE PROVIDER CERTIFICATION

Please provide the following information:

Note to Provider: Answer, fully and completely, all applicable parts. Please attach supporting documentation/medical documentation as appropriate. The CDC's guidance "Summary Document for Interim Clinical Considerations for Use of COVID-19 Vaccines Currently Authorized or Approved in the United States" is attached.

Name of Patient: _____

Patient should not be immunized for COVID-19 for the following reason(s): (Please be as specific as possible including the medical condition that is a contraindication for the COVID-19 vaccine consistent with CDC guidance and the duration of the qualifying medical condition.)

I certify that my patient has a known medical condition, described above, which is a recognized medical contraindication to the COVID-19 vaccine, and it is my medical recommendation that this patient should not receive the following COVID-19 vaccination(s):

- Pfizer BioNTech COVID-19
- Moderna COVID-19
- Johnson & Johnson/Janssen COVID-19 Vaccine

Healthcare Provider's Signature: _____

Date: _____

Provider's Name and Credentials (print): _____

Medical Institution or Practice: _____

Specialty: _____

Phone Number: _____

Street Address: _____

City/State/ZIP: _____