Research College of Nursing

Medical Exemption Request & Waiver

Influenza Vaccination

Student Information – *To be completed by student*

Printed Name: | 3-4 ID:

Date: | Date of Birth:

If you wish to request a medical exemption from vaccination requirement, please sign the waiver below:

_____ (Initial) I understand that the exemption may not be accepted by clinical partners, even if accepted by Research College of Nursing.
_____ (Initial) I understand that if clinical partners do not accept the exemption, I may not attend clinicals at those facilities.
_____ (Initial) I understand that if I cannot complete clinical at my assigned clinical facility, I will not pass the clinical course.
_____ (Initial) I understand that failure to pass the clinical course could result in failure to graduate on time or dismissal from the program.
_____ (Initial) I agree not to hold Research College of Nursing liable or accountable if I am unable to complete clinical courses, including if graduation is delayed or I am dismissed from the program because of the course failure.
_____ (Initial) I understand that without vaccination, I am at increased risk to acquire, and/or transmit disease, which could lead to serious illness or death.

Printed Name:_____ Date:_____

Signature:_____

Healthcare Provider Information – *To be completed by healthcare provider*

Printed Name: | Provider Specialty:

NPI: | Phone Number:

Licensed Healthcare Provider: Please list the contraindications / precautions or other medical condition / disability that apply to this patient and sign and date this form. Licensed Healthcare Provider must include either a treating physician (M.D. or D.O.) or treating advanced practice professional (nurse practitioner or physician assistant). **Note: Health Care Providers cannot sign their own exemption / certification request.**

Vaccine Contraindication Certification (list all that apply) – ***Requires healthcare provider signature*** **Note – Contraindication to one vaccine does not preclude receipt of another vaccine type**

I attest that I have a healthcare provider-patient relationship with the employee identified above and that the above statements are true and accurate.

Healthcare Provider Signature: Date:

For internal use only:
(Post-initial review)
This form is:

- ☐ Complete
- ☐ Incomplete

Internal review date (if applicable):

Comments:

Completed forms must be submitted to the Dean at Rebecca.Saxton@researchcollege.edu.