

**COVID-19 Vaccination Requirement  
Request for Deferral Due to  
Pregnancy- for Students**

Student Name: \_\_\_\_\_ Emory ID #: \_\_\_\_\_

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**Please write your initials in the space next to “Acknowledged” to confirm you have read and understand that statement.**

Emory School of Medicine requires COVID-19 vaccination of our students to prevent COVID-19 and its complications, including death. Acknowledged \_\_\_\_\_

Due to my role, if I am unvaccinated and do not follow masking and social distancing guidelines, I may give COVID-19 to my patients, my teammates, my family and/or friends, even if I have no symptoms. Acknowledged \_\_\_\_\_

I have received education about the effectiveness of COVID-19 vaccinations, as well as possible adverse events. Acknowledged \_\_\_\_\_

I cannot get COVID-19 from the COVID-19 Vaccine. Acknowledged \_\_\_\_\_

I understand that infection with COVID-19 during pregnancy can pose significant risks to me and my baby. The COVID-19 vaccine reduces those risks. Acknowledged \_\_\_\_\_

I understand scientific evidence shows it is safe to get the COVID-19 vaccine during pregnancy. It reduces the risks associated if I am infected with COVID-19 during pregnancy. Acknowledged \_\_\_\_\_

I acknowledge my responsibility to only request a temporary exemption if truly necessary. Acknowledged \_\_\_\_\_

Even though I can receive the COVID-19 vaccine at no charge to myself, I want a deferral. Acknowledged \_\_\_\_\_

Do you provide direct patient care? (Please select a response): Yes \_\_\_\_\_ No \_\_\_\_\_

Has Emory University or Emory Healthcare granted you an exemption from any other mandatory vaccine requirement in the past?

Yes \_\_\_\_\_ No \_\_\_\_\_

**Please explain why you need a deferral due to pregnancy as well as the date of your expected delivery:**

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**If approved, you will be expected to get a COVID-19 vaccine once the deferral period ends. Emory School of Medicine will determine the end date.**

**EMORY**  
UNIVERSITY  
SCHOOL OF  
MEDICINE

I understand that my request for an exemption may not be granted if it is unreasonable, creates undue risk to patient safety or if it creates an undue hardship on my employer. Acknowledged \_\_\_\_\_

Date: \_\_\_\_\_

Emory ID # \_\_\_\_\_

Print Name: \_\_\_\_\_

Signature \_\_\_\_\_

**Please upload completed form in the School of Medicine exemption application.**