EMORY
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MEDICINE

COVID-19 Vaccination Requirement Request for Deferral For Students

Student Name: _____ Emory ID #: _____

Please write your initials in the space next to "Acknowledged" to confirm that 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 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 temporary exemption from the vaccine. 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. [This section must be completed]

_____
_____
_____
_____

What is the time period/end date for the deferral request? _____

Please attach supporting documentation from a licensed healthcare provider supporting your request. This should include medical records with the reaction or other medical reason for the deferral and the anticipated duration of the need for deferral. Please submit your documentation with this completed form. Requests will not be considered without documentation.

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A signature from a licensed healthcare provider is required to validate a medical contraindication that defers the COVID-19 vaccine.

Physician Signature/Date:

_____

Physician Name (Please Print):

_____

Physician Contact Phone Number: _____

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

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 into the School of Medicine exemption application.