Employee COVID-19 Vaccine Requirement
Medical Condition Waiver Request and Certification

Confidential

Board of Regents of the Nevada System of Higher Education

Instructions for completing this Waiver Request.

1. Section 1: To be completed by Employee: Employee and Institution Information.
2. Section 2: To be completed by Employee: Employee Certification.
3. Section 3: To be completed by Health Care Provider: Medical Condition Certification.
4. Section 4: To be completed by Office of Human Resources (Official Use Only).

Section 1: Institution Information (To be completed by Employee)

Employee Name: _____

Address: _____

_____

Telephone Number(s):

Office/Work: _____

Home/Cell: _____

NSHE Institution: _____

Office/Work Location: _____

Office/Work Email Address: _____

Section 2: Employee Certification (To be completed by Employee)

Employee acknowledges, consents, and agrees to the following:

1. NSHE and its officials, including, but not limited to, Office of Human Resources, the Employee COVID-19 Waiver Request Review Committee, and health care experts outside of NSHE, may have access to information contained in this Waiver Request, Employee's personnel file, and other information as necessary to evaluate and review this request. PLEASE NOTE: Individuals having access to Employee's medical information will be required to maintain its confidentiality and it will be used for official purposes only.
2. NSHE and its officials may contact the health care provider listed on this Waiver Request to verify the information provided.
3. If this Waiver Request is granted, Employee may be required to comply with alternative policies and protocols as determined by NSHE and its officials to maintain the health and safety of Employee and all other individuals from COVID-19. Alternative policies and protocols may include, but not be limited to, indoor and outdoor face covering requirements, weekly and/or periodic COVID-19 testing, exclusion from the workplace upon the recommendation of health care professionals due to an outbreak or cluster of the COVID-19 virus. Alternative COVID-19 health and safety policies and protocols for Employee as a condition of granting this Waiver Request may be revised by NSHE and its officials from time to time and as necessary to respond to changing COVID-19 data and recommendations by local, state, and federal government entities.
4. NSHE and its officials may require the information in this Waiver Request to be periodically updated.
5. Failure to provide all required information in this Waiver Request may result in it being denied.

I, _____, hereby certify and request that I be exempt from the Employee COVID-19 Vaccine Requirement because receiving a COVID-19 vaccine series will result in one or more contraindication(s) due to a permanent or temporary medical condition. I further certify and affirm that the information contained in this Waiver Request is being submitted in good faith and is true and correct to the best of my belief and knowledge.

_____ _____

Employee's Signature **Date**

Section 3: Medical Condition Certification (To be completed by Health Care Provider)

Health Care Provider Name: _____

Business Address: _____

_____

Telephone Number:

Office/Work: _____

State Licensed In: _____

License Number: _____

Office/Work Email Address: _____

Permanent Contraindication(s)

☐ A contraindication(s) for a COVID-19 vaccine as recognized by the Centers for Disease Control and Prevention (CDC).

☐ A contraindication(s) for a COVID-19 vaccine as recognized by the manufacturer of the vaccine.

State the vaccine(s): _____

☐ The physical condition of the individual or medical circumstances relating to the individual are such that immunization against COVID-19 is not safe and presents an unreasonable risk of harm to the individual.

Provide details and an explanation for any permanant contraindication(s) that is checked, indicating the specific nature of the medical condition or circumstances that contraindicate immunization with a COVID-19 vaccine (provide any additional documentation or attach written pages as necessary):

_____

_____

_____

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_____

Temporary Contraindication(s)

☐ A contraindication due to a temporary medical condition.

Date Until: _____

Provide details and an explanation for any temporary contraindication(s) (provide any additional documentation or attach written pages as necessary):

_____

_____

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_____

I, _____, hereby certify that I am a licensed physician, nurse practitioner, or physician assistant in good standing and I have examined and/or I am familiar with the above-named Employee's medical history and condition. In my professional judgment and opinion, the Employee should be exempted and granted a waiver from the Employee COVID-19 Vaccine Requirement due to a contraindication(s) that would result in harm if the Employee were administered a COVID-19 vaccine series.

_____ _____

Health Care Provider's Signature **Date**

– Official Use Only –

Section 4: Waiver Request Review (To be completed by Office of Human Resources)

☐ Approved
☐ Denied
☐ Insufficient Information

Date(s)

Initial Review: _____

Review Committee: _____

Human Resources Official

Name: _____

Title: _____

Health and Safety Conditions of Approval

As a condition of approval, Employee must abide by the following COVID-19 health and safety measures:

_____

_____

_____

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_____

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_____