CALIFORNIA STATE UNIVERSITY
SAN BERNARDINO

Human Resources Services
5500 University Parkway, San Bernardino, CA 92407| 909.537.5138

MEDICAL EXEMPTION REQUEST FORM – COVID-19 Vaccine

Employee Name: _____ Phone: _____

Email: _____

I, _____ (Name of licensed, board certified MD, DO, PA, NP) hereby certify that the above-named employee has a medical condition that contraindicates their vaccination with the COVID-19 vaccine.

This contraindication is ☐ Permanent or ☐ Temporary
If temporary: The expiration date of the exemption for this vaccine is: _____

Medical Provider Name: _____

Name of Medical Practice: _____

Address: _____ City: _____ State: ___ Zip: _____

Phone: _____ Email: _____

Medical Provider's Signature: _____ Date: _____

Once completed, this form may be either returned to the employee or mailed to the address below. The employee may choose to either return the form to the ADA Coordinator, in person (SH 100), email to Alisha.Carnahan@csusb.edu, or mail it to:

Human Resources Services
Attn: Alisha Carnahan
California State University, San Bernardino
5500 University Parkway
San Bernardino, CA 92407