University of California Medical Exemption Request Form

BERKELEY • DAVIS • IRVINE • LOS ANGELES • MERCED • RIVERSIDE • SAN DIEGO • SAN FRANCISCO

SANTA BARBARA • SANTA CRUZ

Name of Patient: ______________________________

Status: ☐ Faculty ☐ Staff

Date of Birth: ____________________ MRN: ____________________

Name of Health Care Provider: ______________________________

License Number: ____________________ Expiration Date: __________

State of Issuance: ______________________________

License Type: ☐ Medical or Osteopathic Physician ☐ Nurse Practitioner ☐ Physician's Assistant

Practice Address: ______________________________

Email: ____________________ Phone: ____________________

I hereby certify that the above-referenced patient qualifies for a medical exemption from influenza vaccine, as further provided below:

Reason for Exemption:

☐ CDC Contraindication ☐ CDC Precaution ☐ Manufacturer's Insert Contraindication

This contraindication or precaution is: ☐ Permanent ☐ Temporary

- If temporary, the expiration date for the exemption is: ____________________

Signature of Health Care Provider: ______________________________

Date of Signature: ______________________________

- Campus faculty and staff, email completed form and supporting documentation to: eec@uci.edu
- UCIMC and School of Medicine faculty and staff, email completed form and supporting documentation to: FluExempt@hs.uci.edu

For Official Use Only:

☐ Approved ☐ Denied Date: ____________________

Name: ____________________ Title: ____________________

Signature: ______________________________

UC Location: Irvine ______________________________