MEDICAL CERTIFICATION
Exception to SARS-CoV-2 (COVID-19) Vaccination Requirement

The City of San Jose requires that its employees, temporary employees, interns, volunteers, and commissioners working or volunteering onsite at a City facility or other City location be vaccinated against COVID-19 infection. The City may grant exceptions to this requirement based on (a) medical exemption due to a contraindication or precaution to COVID-19 vaccination recognized by the U.S. Centers for Disease Control and Prevention (CDC) or by the vaccines' manufacturers or (b) disability, provided that the individual's request for such an exception is supported by medical certification from their qualified licensed health care provider.

Health Care Provider Name	License Type, # and Issuing State
Full Name of Patient	Date of Birth of Patient
Health Care Provider Phone	Health Care Provider Email

Please complete Part A of this form if one or more of the contraindications or precautions to COVID-19 vaccination recognized by the CDC or the vaccines' manufacturers apply to this patient with respect to all FDA-authorized COVID-19 vaccines.

Please complete Part B if this patient has a disability, as defined below, that makes COVID-19 vaccination inadvisable in your professional medical opinion. Both sections may be completed if both apply to this patient. Important: Do not identify the patient's diagnosis, disability, genetic information[1], or other medical information as this document will be returned to the ***City of San Jose***, which employs, contracts with, or otherwise works with patient.

Part A: Contraindication or Precaution to COVID-19 Vaccination

☐I certify that _____ is my patient, and that one or more of the contraindications or precautions recognized by the CDC or by the vaccines' manufacturers for each of the currently available COVID-19 vaccines applies to the patient listed above. For that reason, COVID-19 vaccination using any of the currently available COVID-19 vaccines is inadvisable for this patient in my professional opinion. The contraindication(s) and/or precaution(s) is/are:

☐Permanent ☐Temporary. If temporary, the expected end date is: _____.

Part B: Disability That Makes COVID-19 Vaccination Medically Inadvisable

"Disability" is defined as a physical or mental disorder or condition that limits a major life activity and any other condition recognized as a disability under applicable law. "Disability" includes pregnancy, childbirth, or a related medical condition where your medical opinion is that COVID-19 vaccination is inadvisable.

☐I certify that _____ is my patient and has a disability, as defined above, that makes COVID-19 vaccination medically inadvisable in my professional opinion. The patient's disability is:

☐Permanent ☐Temporary. If temporary, the expected end date is: _____.

_____ _____

Signature of Health Care Provider Date

[1] Per the Genetic Information Nondiscrimination Act of 2008 (GINA), "genetic information" includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information[1] of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.