Employee Request for Medical Exemption from COVID-19 Testing Form

Name: _____

EMPLID: _____ Email: _____

Phone: _____

The University of Akron is committed to providing an inclusive and supportive environment for all and recognizes that some may not be tested against COVID-19 for medical reasons, including but not limited to, a positive COVID-19 test in the last ninety (90) days. A medical exemption may be granted upon receipt of a completed form (below), not more than 6 months old, signed and certified by a licensed healthcare provider, not related to the submitter, and whose specialty is appropriate to the associated condition. Medical exemptions expire when the medical condition(s) contraindicating COVID-19 testing changes in a manner that permits testing.

The assigned expiration date is at the sole determination of The University of Akron. Individuals with an approved exemption may be required to comply with other preventive requirements as specified in the exemption approval and as may be updated by later notification and/or posting of requirements. In the event of an outbreak on or near campus, individuals holding exemptions may be excluded from all campus facilities and activities, for their protection, until the outbreak is declared to be over.

The Office of Benefits Administration will review all requests, though approval is not guaranteed. After your request has been reviewed and processed, you will be notified, in writing, if an exemption has been granted. If the approved exemption contains an expiration date, you will be expected to complete a new request at that time.

Should the condition continue or the current exemption expire, a new request with updated documentation is required. Decisions are final and not subject to appeal. Individuals are permitted to reapply if new documentation and information should become available.

Important Note: **Requesting an exemption does not equate to registration as a student or employee with a disability. If you require disability-related accommodations outside of this exemption, you must go through the appropriate University disability registration process.**

In order to submit a request, please:

- Complete this form;
- Have your Licensed Health Care Provider provide the required documentation or testing results; and
- Submit the completed documents.

Note: Incomplete submissions will not be reviewed. Be sure all forms and documentation are submitted at one time.

Initial next to each of the statements below:

	I request exemption from the COVID-19 testing requirements due to my current medical condition. I understand and assume the risks of non-testing.
	Because I have not been tested and in order to protect my own health and the health of the community, I will comply with other preventive guidance.
	I agree that if I contract COVID-19, I will immediately report it to The University of Akron reporting system and comply with all isolation and quarantine procedures specified by Summit County Health officials and The University of Akron and will remove myself from the University community if so advised.
	I understand that this exemption will expire when the medical condition(s) contraindicating testing changes in a manner that permits testing.
	I understand and agree to comply with and abide by all University COVID-19 policies and procedures, unless granted an exemption therefrom by the University.
	I understand that this exemption is only valid for the approved period and I may need to submit a new request for any subsequent changes, new medical contraindications, or on expiration of an approved exemption.
	I authorize my licensed health care provider to provide The University of Akron with medical information about my medical exemption for the COVID-19 testing.
	I certify that the information I have provided on and in connection with this request is accurate and complete as of the date of this submission. I understand this exemption may be revoked and I may be subject to disciplinary action if any false information has been used to request an exemption.

Printed Name: _____

Signature: _____

Date: _____

☐ By checking this box and typing my name above, I understand and agree that I am submitting this document electronically and that it is the legal equivalent of having placed my handwritten signature on this page.

ATTACH DOCUMENTATION FROM LICENSED HEALTH CARE PROVIDER

Return all forms to The University of Akron, Office Benefits Administration, Akron OH 44325 or benefits@uakron.edu