**CERTIFICATION FROM PHYSICIAN, NURSE PRACTITIONER, OR OTHER LICENSED MEDICAL PROFESSIONAL PRACTICING UNDER THE LICENSE OF A PHYSICIAN**

The Peralta Community College District (“District”) requires that its students that attend classes on-site at a District facility or other District location be vaccinated against COVID-19infection. The District may grant exceptions to this requirement based on (a) medical exemption due to contraindication or precaution to COVID-19 vaccination recognized by the U.S. Center for Disease Control and Prevention (CDC) or the vaccines manufacturers or (b) a disability within the meaning of Title II of the Americans with Disabilities Act (“ADA”) and Section 504 of the Rehabilitation Act that substantially limits the student’s ability to be fully vaccinated against COVID-19.

Heath Care Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

License Type, # and Issuing State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Care Provider Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Care Provider Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Supervisor and License # (for a Physician Assistant working under a Physician’s License): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Full Name of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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’ manufactures 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, or other medical information as this document will be returned to the Peralta Community College District.

**CERTIFICATION FROM PHYSICIAN, NURSE PRACTITIONER, OR OTHER LICENSED MEDICAL PROFESSIONAL PRACTICING UNDER THE LICENSE OF A PHYSICIAN**

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

**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” means a physical or mental impairment that substantially limits the student’s ability to engage in a major life activity, such as the ability to work, care for themselves, perform manual tasks, walk, see, hear, eat, sleep, or engage in social activities. An impairment substantially interferes with the accomplishment of a major life activity when the individual's important life activities are restricted as to the conditions, manner, or duration under which the student can perform them in comparison to most people.

I certify that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is my patient, and has a disability, as defined above, that makes COVID-19 vaccination medical inadvisable in my professional opinion. The patient’s disability is:

* + Permanent
  + Temporary.

If temporary, the expected end date is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Signature of Heath Care Provider Date