NSU Florida

Medical Certification Form

To Be Completed by Employee's Licensed Medical Practitioner

Employee Name: _____

Date Requested: _____

Attention Medical Practitioner:

Nova Southeastern University requires a completed COVID-19 vaccination as a condition of employment. The above-named employee is requesting an exemption from this vaccination requirement. A medical exemption from the COVID-19 vaccination may be allowed for certain recognized contraindications and/or pregnancy or pregnancy related medical conditions, or anticipated pregnancy.

Please complete the form below. Should you have any questions please contact NOVA SOUTHEASTERN UNIVERSITY OFFICE OF HUMAN RESOURCES at ohr-ada@nova.edu.

The above person should not be immunized for COVID-19 for the following reasons:

☐ 1. History of previous allergic reaction to indicate an immediate hypersensitivity reaction to a component of the vaccine.

Licensed medical practitioner to add explanation here:

☐ 2. The physical condition of the person or medical circumstances relating to the person are such that immunization is not considered safe. Please specify which of the authorized COVID-19 vaccines are clinically contraindicated for the person to receive, the recognized clinical reasons for the contraindication, and probable duration of the medical condition.

Licensed medical practitioner to add explanation here:

☐ 3. Confirmation of pregnancy or pregnancy-related medical condition – Please provide due date and any other related documentation including postpartum requirements.

Licensed medical practitioner to add explanation here:

The following option is available ONLY to employees with a regular assigned work location in the state of Florida that is NOT a certified NSU healthcare facility participating in Medicare or Medicaid.

☐ 4. Anticipated pregnancy- Healthcare provider is aware the person intends to become pregnant and is of childbearing age.

Licensed medical practitioner to add explanation here:

CERTIFICATION STATEMENT: For the above stated reasons, I hereby recommend _____ be exempted from the requirement to complete the COVID-19 vaccination.

Licensed Medical practitioner signature: _____

Print signature:_____

Date: _____

Practitioner address:_____

Practitioner phone number: _____