

**Stony Brook University**  
**Request for Medical Exemption from the COVID-19 Vaccine**

**Name:** \_\_\_\_\_ **SBU ID:** \_\_\_\_\_  
**Stony Brook Email:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**For employees:**  
**Job Title:** \_\_\_\_\_  
**Department:** \_\_\_\_\_

**For students:**  
**School (e.g., College of Business):** \_\_\_\_\_

Immunization requirements are in place to protect the health and safety of our community, including our employees, students, and vulnerable patient population. Residential students, students accessing SBU facilities in-person, and “covered personnel” as defined by order of the Department of Health<sup>1</sup> are required to be fully vaccinated, subject to limited exemptions.

***Clinician Section***

***(This section must be completed and signed by a licensed Physician, Physician’s Assistant or Nurse Practitioner.)***

Please select which of the COVID-19 vaccine contraindications identified by the CDC apply:

- Severe allergic reaction (anaphylaxis) after a previous dose or to a component of the COVID-19 vaccine, including polyethylene glycol (PEG). ***(Describe reaction/response below and contraindication to alternative vaccines.)***
- Immediate allergic reaction to previous dose or known (diagnosed) allergy to a component of the vaccine. ***(Describe reaction/response below and contraindication to alternative vaccines.)***

Please note that ***none of the following are considered contraindications*** to the COVID-19 vaccine.

- Local injection site reactions to previous COVID-19 vaccines (erythema, induration, pruritus, pain)
- Expected systemic vaccine side effects in previous COVID-19 vaccines (fever, chills, fatigue, headache, lymphedema, diarrhea, myalgia, arthralgia)
- Previous COVID-19 infection
- Vasovagal reaction after receiving a dose of any vaccination
- Being an immunocompromised individual or receiving immunosuppressive medications
- Autoimmune conditions, including Guillain-Barre syndrome
- Allergic reactions to anything not contained in the COVID-19 vaccine, including injectable therapies, food, pets, oral medications, latex, etc. (Please note the COVID vaccine does not contain egg or gelatin.)
- Alpha-gal syndrome
- Pregnancy, undergoing fertility treatment, intention to become pregnant or currently breastfeeding (Please note the American College of Obstetricians and Gynecologists, the Society for Maternal-Fetal Medicine and the American Society for Reproductive Medicine all strongly recommend COVID-19 vaccination during pregnancy.)
- The medical condition of a family member or others residing in the same household as the employee

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<sup>1</sup> Covered personnel are defined as “[a]ll persons employed or affiliated with a covered entity [*i.e.*, a “general hospital or nursing home pursuant to section 2801 of the Public Health Law”], whether paid or unpaid, including but not limited to employees, members of the medical and nursing staff, contract staff, students, and volunteers, who engage in activities such that if they were infected with COVID-19, they could potentially expose, patients, residents, or personnel working for such entity to the disease.”

Clinician Certification: **By completing this form, you certify that the above-named individual is a patient under your care and has been examined by you. You further certify that different methods of vaccinating against COVID-19 have been fully considered and that the patient has the contraindication indicated above that precludes any/all available vaccinations for COVID-19.** Information about approved medical exemptions for COVID-19 vaccination can be reviewed at [cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html](https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html).

|                       |  |                       |  |
|-----------------------|--|-----------------------|--|
| Name of Clinician     |  | Clinical Provider ID# |  |
| Clinician's Signature |  | Practice Name         |  |
| Date of Signature     |  | Practice Phone #      |  |

**Employee Section:**

By signing this form, I certify that the information I am submitting in support of my request for an exemption is complete and accurate to the best of my knowledge, and that if my request for an exemption is granted, I will comply with all SBU requirements for unvaccinated individuals, as may be updated or modified. I further agree that by signing this form, I am providing permission for SBU to contact my medical provider if more information or documentation is needed to support my exemption request. I understand that knowingly providing false or inaccurate information may subject me to administrative action up to and including termination.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Submit your completed form, signed by your clinician, as follows:

- Students: Wolfie Health Portal
- Hospital employees: Fax to 631-444-6199 or email to [sbuh\\_hr\\_employee\\_health\\_and\\_wellness@stonybrookmedicine.edu](mailto:sbuh_hr_employee_health_and_wellness@stonybrookmedicine.edu)
- LISVH employees: Employee Health (in person) or fax to 631-444-8680
- Employees of the West Campus, Health Sciences Center, and the School of Medicine (non-clinical): email to [WC\\_Medical\\_Exemption\\_Request@stonybrook.edu](mailto:WC_Medical_Exemption_Request@stonybrook.edu)

Applicants will be notified, in writing, as to the outcome of their request.

This form will be treated confidentially.

Please contact Student Health Services at 631-632-6740, Hospital Employee Health at (631) 444-7767, or LISVH Employee Health at (631) 444-8526 if you have any questions.