UNIVERSITY OF CALIFORNIA
DEFERRAL REQUEST FORM
Exception to SARS-CoV-2 (COVID-19) Vaccination Requirement
Based on Pregnancy or Recent COVID-19 Diagnosis or Treatment

EMPLOYEE OR STUDENT NAME	EMPLOYEE OR STUDENT ID
JOB TITLE (IF APPLICABLE)	LOCATION
DEPARTMENT (IF APPLICABLE)	SUPERVISOR (IF APPLICABLE)
PHONE NUMBER	EMAIL

This form should be used by University employees and students to request a Deferral of the COVID-19 Primary Series vaccination requirement in the University's SARS-CoV-2 Vaccination Program due to pregnancy or recent COVID-19 diagnosis or treatment.

It should also be used by health care workers subject to the California Department of Public Health's Health Care Worker Vaccine Requirement ("CDPH order") to request a Deferral of the CDPH order's booster requirement due to recent COVID-19 diagnosis. Those who are permitted by University policy and applicable public health directives to decline COVID-19 boosters may defer booster administration by using the *Vaccine Declination Statement – Declination of COVID-19 Booster* form.

Fill out Part A to request a Deferral of the Primary Series due to pregnancy. Fill out Part B to request a Deferral due to COVID-19 diagnosis or treatment within the last 90 days. If you are filling out Part B, your request may need to be supported by a health care provider's certification. Some local (city/county) public health departments have issued orders specifying that the certification must be signed by a physician, nurse practitioner, or other licensed medical professional practicing under the license of a physician.

Part A: Request for Deferral of the Primary Series Due to Pregnancy

☐ I am currently pregnant and am requesting a Deferral of the COVID-19 Primary Series vaccination requirement during my pregnancy. My anticipated due date is ________________. Health care workers subject to the CDPH order are not eligible for Deferrals based on pregnancy.

Part B: Request for Deferral Due to COVID-19 Diagnosis or Treatment

Check all that apply:

☐ Primary Series. I am requesting a Deferral of the COVID-19 Primary Series vaccination requirement because I have been diagnosed with COVID-19 within the last 90 days. Health care workers subject to the CDPH order are not eligible for this Deferral. My request is supported by the attached confirmed laboratory results or certification from my health care provider.

☐ Primary Series. I am requesting a Deferral to the COVID-19 Primary Series vaccination requirement because I have been *treated* for COVID-19 within the last 90 days. Health care workers subject to the CDPH order are not eligible for this Deferral. My request is supported by the attached certification from my health care provider.

☐ Booster. I am a health care worker subject to the CDPH order, and I am requesting a Deferral to the COVID-19 booster vaccination requirement

because I have been *diagnosed* with COVID-19 within the last 90 days. My request is supported by the attached certification from my health care provider.

While my request is pending and if it is approved, I understand that I must comply with the Location's Non-Pharmaceutical Intervention requirements (e.g., face coverings, regular asymptomatic testing) for individuals who are not Up-To-Date on COVID-19 vaccination as a condition of my Physical Presence at any University Location/Facility or Program. I also understand that I must comply with any additional Non-Pharmaceutical Interventions applicable to my position, as required by my Location.

I verify the truth and accuracy of the statements in this request form.

Employee/Student Signature: ________________________ Date: ________________

Date Received by University: ___________ By: ______________________________

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CERTIFICATION FROM HEALTH CARE PROVIDER

Your patient is a University of California employee and/or student who has requested a Deferral of the University's COVID-19 vaccination requirement based on COVID-19 diagnosis or treatment within the last 90 days. Your patient is seeking to support their request for such a Deferral with a 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
PATIENT'S EMPLOYEE/STUDENT ID NUMBER	HEALTH CARE PROVIDER PHONE/EMAIL
PHYSICIAN SUPERVISOR AND LICENSE # (FOR A PHYSICIAN ASSISTANT WORKING UNDER A PHYSICIAN'S LICENSE)	

Please note the following from the Genetic Information Nondiscrimination Act of 2008 (GINA), which applies to all University employees:

> *The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, 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 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.*

Please complete the following. Important: Other than COVID-19 diagnosis, do not identify the patient's diagnosis, disability, or other medical information as this document will be returned to the University.

☐ I certify that my patient has been diagnosed with COVID-19 within the last 90 days. My patient's COVID-19 diagnosis was on ___________________.

☐ I certify that my patient has been treated for COVID-19 within the last 90 days. My patient's last day of COVID-19 treatment was on __________________.

☐ I certify that my patient is being actively treated for COVID-19. The expected end date of treatment is: ___________________.

____ ___________________________

Signature of Health Care Provider Date