

# COVID-19 Medical Exemption Request

## PART 1 – STUDENT/EMPLOYEE/GUEST INFORMATION

Last Name:	First Name:	Date of Birth (YYYY/MM/DD):
I am a: Student    Employee    Visitor/Guest/Volunteer	Student/Employee Number:	
Employee/Student Number:	Date:	
Home Address:		
City:	Province:	Postal Code:
Telephone Number:	Email Address:	
Program (Student) / Department (Employee) / Event or Reason for Attending Campus (Visitor/Volunteer/Guest):		

## PART 2 – AUTHORIZATION AND CONSENT TO RELEASE MEDICAL INFORMATION

**For Students and Visitors/Guests/Volunteers (or parent/legal guardian for those under 18 years of age):** I hereby request and authorize that medical information and related data pertaining to my/my child's current request for medical exemption be given to or discussed with the College's Healthy Campus Team and external medical and legal counsel, as may be necessary. This information will be used for the purpose of administering Mohawk College's COVID-19 Vaccination Policy Statement requirement and Accommodation Programs. With this consent I authorize Mohawk College to:

- Collect information related to the exemption request and coordinate accommodation.
- Contact my treating physician or other medical practitioners for clarification of information and follow up, by telephone and/or correspondence, related to the circumstances regarding the reason(s) for the medical absence, and/or accommodation including, but not limited to: assessments, consultations and testing.
- If required, arrange Independent Medical Evaluations for the purpose of clarification.
- Provide information to the College's Healthy Campus Team as well as relevant academic supervisors, instructors and/or faculty administrators as may be necessary to facilitate accommodation(s), regarding the expected duration of my approved exemption, restrictions/limitations, and academic accommodations, which may include but are not limited to: testing, personal protective equipment and physical distancing requirements.

**For Employees:** I hereby request and authorize that medical information and related data pertaining to my current request for COVID-19 vaccine exemption be given to or discussed with the College's Healthy Campus Team, Occupational Health and Safety and Human Resources Department. This information will be used for the purpose of administering Mohawk College's COVID-19 Vaccination Policy Statement requirement and Accommodation Programs. With this consent I authorize Mohawk College to:

- Collect information related to the exemption request, coordinate my return to work and/or accommodation.
- Contact my treating physician or other medical practitioners for clarification of information and follow up, by telephone and/or correspondence, related to the circumstances regarding the reason(s) for the medical absence, and/or medical accommodation including, but not limited to: assessments, consultations and testing.
- If required, arrange Independent Medical Evaluations for the purpose of clarification.
- Provide information to Health Campus Team and my employment supervisor as may be necessary to facilitate accommodation regarding expected duration of exemption, restrictions/limitations, and workplace accommodations, which may include but are not limited to: testing, personal protective equipment and physical distancing requirements.

Confidential medical information will not be discussed outside the parameters of this consent form without your separate, specific consent. Please note, Mohawk College is unable to reimburse you for any fee associated with completion of this form, except as may be specifically provided for in a relevant collective agreement.

Please sign to authorize below, include date, and give this copy to your Physician for completion of Part 2. For those under 18 years of age, please have a parent/legal guardian sign this form.

### Notice of Collection of Personal Information

The information gathered on this form is collected under the authority of The Ontario Colleges of Applied Arts and Technology Act, 2002, S.O. 2002, Schedule F ("OCAAT Act"). The information is used only for the purposes of a determining and/or implementing an accommodation to the College's mandatory vaccination requirement, for statistical purposes, or for legal requirements. Personal information provided on this form will not be used for any unrelated purpose without consent. This information is protected and is being collected pursuant to section 39(2) and section 42 of the Freedom of Information and Protection of Privacy Act of Ontario (RSO 1990). Questions regarding the collection or use of this personal information should be directed to the General Counsel and Corporate Secretary's Office at 905-575-1212 ext. 2189.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

# COVID-19 Medical Exemption Request

Please identify the medical exemption/accommodation(s) you are requesting:

**SECTION 3 – COVID-19 VACCINE EXEMPTION REQUEST  
(TO BE COMPLETED BY PHYSICIAN OR RN (EC))**

Physician's or RN(EC) Name:		Physician's or RN (EC) Address	
City:	Province:	Postal Code:	
Physician's or RN(EC) Telephone:		Physician's or RN (EC) Fax:	
Physician's or RN (EC) Signature:		Physician's or RN (EC) Registration No.:	
Date Completed:		End Date or Re-Evaluation Date:	

**Please answer the questions below as they relate to the requested exemption to COVID-19 Vaccination.**

1. Do you recommend this individual receive an approved COVID-19 vaccination?    Yes            No  
Please provide medical rationale.

2. Nature of the medical condition/injury/illness:

3. Has maximum medical recovery been reached? Is further treatment recommended? Please explain and include prognosis.

**PLEASE COMPLETE THIS FORM AND SEND TO [HEALTHYCAMPUS@MOHAWKCOLLEGE.CA](mailto:HEALTHYCAMPUS@MOHAWKCOLLEGE.CA)**