BELLEVUE COLLEGE
HUMAN RESOURCES

MEDICAL VACCINE EXEMPTION REQUEST

Employee Information (Employee to Complete):

Name:

Birthdate:

BC Employee ID Number:

Health Care Provider Information and Instructions

The employee listed on the COVID-19 Vaccination Medical Exemption Health Care Provider Form (above) has disclosed they have a medical condition, which may prevent them from receiving an authorized COVID-19 vaccine. Bellevue College requests that you as the employee's health care provider complete the form below for verification purposes. For the purpose of this medical exemption request, a health care provider includes all qualified and licensed MD, ND, DO, ARNP, or PA professionals.

Please follow these steps:

1. Complete the information on the COVID-19 Vaccination Medical Exemption Health Care Provider Form. All questions and information must be answered for the college to consider the employee's request for an exemption.
2. The form requires a physical signature or secured electronic signature. Please do not type your name on the signature line.

Medical Exemption Information (Healthcare Provider to complete):

This employee has disclosed to Bellevue College that they have a health condition which prevents them from receiving a COVID 19 vaccination. We are requesting that you complete the following information to verify the employee's need for an exemption.

Health Care Provider Name:

Health Care Provider License Number:

Health Care Provider Address:

Health Care Provider Phone:

Health Care Provider Email:

What is your area of practice or medical expertise?

1. Please identify the health condition the student experiences and include how this condition prevents them fromreceiving a COVID 19 Vaccination:

2. Is this vaccination exemption the result of a permanent or temporary health condition, and if temporary, please includeexpected duration?

Health Care Provider Signature

I have discussed the benefits and risks of immunizations with the employee, and I certify that I am a qualified and licensed MD, ND, DO, ARNP, or PA, and declare that, in my professional opinion, the above responses are true and accurate to the best of my knowledge and ability.

Health Care Provider Signature:

Date:

This form requires a physical signature or secured electronic signature. Please do not type your name into the space provided. This form can be submitted to the Human Resources secure fax line at 425-564-3173.