SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
REQUEST FOR MEDICAL EXEMPTION TO THE COVID-19 VACCINATION

Employees of the South Carolina Department of Disabilities and Special Needs (DDSN) may request an exemption from the requirement to be fully vaccinated against COVID-19 in accordance with the Center for Medicare and Medicaid Services (CMS) Omnibus COVID-19 Health Care Staff Vaccination Interim Final Rule (IFR). One qualifying exemption is for an underlying medical condition or disability that contraindicates administration of the vaccine. An employee may request a medical exception by returning this form to the South Carolina Department of Disabilities and Special Needs Division of Human Resources (DDSN-HR). Please note employees that qualify for an exemption will instead be required to comply with alternative health and safety protocols, including social distancing and mask wearing.

To request a medical exemption from the COVID-19 vaccination requirement:

1. An employee must complete Part I of this form, and
2. A medical provider must complete Part II of this form.

PART 1 – TO BE COMPETED BY THE EMPLOYEE:

Employee Name:_____ Date of Request:_____

Employee Position:_____ Location:_____

Employee's Supervisor:_____ Employee Number:_____

MEDICAL EXCEPTION REQUEST

I am requesting a medical exception to the requirement for COVID-19 vaccination or delay because of a temporary condition or medical circumstance. I declare that the information provided below is true and accurate, to the best of my knowledge.

_____ Date:_____

Employee Signature

PART II – TO BE COMPLETED BY THE EMPLOYEE'S MEDICAL PROVIDER

Employee Name:_____

MEDICAL CERTIFICATION FOR COVID-19 VACCINE EXCEPTION

The individual named above is requesting a medical exception to the requirement for COVID-19 vaccination or a delay because of a temporary condition. Please complete this form to assist the South Carolina Department of Disabilities and Special Needs (DDSN) in its reasonable accommodation process.

Description of the medical condition:

Medical Condition Duration: ☐Temporary ☐Permanent

If the condition is temporary, please explain when it is expected to end, allowing for COVID-19 vaccination to resume.

Medical Provider Printed Name and Title:_____

_____ Date:_____

Medical Provider Signature

Requests for exemptions from vaccination requirements should be emailed to COVID-19ExemptionRequest@ddsn.sc.gov. If you do not have access to email, you may make a request to your local Human Resources representative for the "Request for Exemption" to be sent on your behalf to the email listed above.

TO BE COMPLETED BY DDSN – DIVISION OF HUMAN RESOURCES

Exemption Approved: ☐Yes ☐No

Duration of Accommodation (*if applicable*):_____

_____ Date:_____

Human Resources Staff Signature