



**Request for a WAIVER from the
Immunization Requirement**

Employee Information				
Name: _____				
Student ID#: _____				
Current Mailing Address: _____				
	Address	City	State	Zip Code
Email Address: _____				
Date of Birth: _____		Current Phone: _____		

I. Identify the category of your request (circle applicable reason):

Medical
(requires physicians' signature)

Religious

Online Program Only

2. Please describe the reason for your request in the space below:

Employee Signature: _____ **Date:** _____

Health Care Provider Documentation *(required for medical waiver request):*

I certify that this employee has legitimate medical reasons for inadequate immunity because (state reason below):

Health Care Provider's Signature/Title/Date

Print Name and Title

Current Mailing Address: _____

Address

City

State

Zip Code

Telephone: _____

Upload this completed form to your Med+Proctor employee account.