Certification of Health Care Provider
For an Immunocompromised Household Member

Purpose of form: The below-named employee of the University of California has requested a modification to their work duties and responsibilities due to a member of their household being moderately to severely immunocompromised. The medical certification form will provide the University with the information needed to determine if the non-employee household member meets the eligibility requirements for the modifications requested. Section II must be completed by the immune compromised household member's health care provider.

Directions to Employee: Please complete and sign Section I of this form before giving the form to the named member of your household or their health care provider.

This form must be completed and returned one week prior to the initiation of the work modification request. Please submit the completed form by email to apo@ucsc.edu.

Section I: To be completed by the EMPLOYEE	
Employee Name:	
Employee's Department:	
Name of Patient and Household Member:	
CERTIFICATION AND SIGNATURE	
I, the undersigned employee of the University of California, certify that the individual named above is a member of my immediate household.	
Employee Signature:	Date:

Section II: To be completed by the HEALTH CARE PROVIDER
Instructions to the HEALTH CARE PROVIDER: The employee listed above has requested a modification to their work duties and responsibilities due to your patient's having a health condition that makes your patient eligible for an additional COVID-19 vaccine dose under the current CDC guidelines for individuals who are moderately to severely immunocompromised. Please answer fully and completely below. Your answer should be based on your medical knowledge, experience, and examination of the patient. Please be sure to sign and date the form at the end of this section. IMPORTANT: DO NOT DISCLOSE ANY UNDERLYING DIAGNOSIS WITHOUT THE PATIENT'S CONSENT. THE GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 (GINA): 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.

THE CALIFORNIA GENETIC INFORMATION NONDISCRIMINATION ACT OF 2011 (CalGINA): The California Genetic Information Nondiscrimination Act of 2011 (CalGINA) prohibits employers and other covered entities from requesting, or requiring, genetic information of an individual or family member of the individual except as specifically allowed by law. To comply with CalGINA, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information," as defined by CalGINA, includes information about the individual's or the individual's family member's genetic tests, information regarding the manifestation of a disease or disorder in a family member ofthe individual, and includes information from genetic services or participation in clinical research that includesgenetic services by an individual or any family member of the individual. "Genetic Information" does not include information about an individual's sex or age.

Provider's Name:	
Business Address:	
Phone:	

MEDICAL FACTS

Is the patient's health condition included under the current CDC recommendation for an additional COVID-19 vaccine dose for individuals who are moderately to severely immunocompromised? (Select ONE)

Yes: ☐ No: ☐

SIGNATURE

Signature of Health Care Provider:	Date: