This form should be used by AEG employees to request an Exemption to the COVID-19 vaccination requirement based on (a) Medical Exemption due to a Contraindication or Precaution to COVID-19 vaccination recognized by the U.S. Centers for Disease Control and Prevention (CDC) or by the vaccines' manufacturers or (b) Disability.

Fill out Part A to request an Exemption based on Medical Exemption. Fill out Part B to request an Exemption based on Disability. Both sections may be completed if both apply to you. Important: Do not identify any diagnosis, disability, or other medical information. That information is not required to process your request.

Part A: Request for Exemption Based on Medical Exemption

- The Contraindications or Precautions to COVID-19 vaccination recognized by the CDC or by the vaccines' manufacturers apply to me with respect to all available COVID-19 vaccines. For that reason, I am requesting an Exemption to the COVID-19 vaccination requirement based on Medical Exemption. My request is supported by the attached certification from my health care provider. I understand that some local (city/county) public health departments have issued orders specifying that the certification must be signed by a physician, nurse practitioner, or other licensed medical professional practicing under the license of a physician.

- Guidance on Contraindications or Precautions can be found at the following links:
  CDC Clinical Considerations: [CDC Clinical Consideration COVID-19 Vaccines](#)
Pfizer: [Pfizer Medical Information & Contraindications](#); [CDC Pfizer Information](#)
Moderna: [Moderna FDA Information](#); [CDC Moderna Information](#)

Part B: Request for Exemption Based on Disability

- I have a Disability and am requesting an Exemption to the COVID-19 vaccination requirement as a Disability accommodation. My request is supported by the attached certification from my health care provider. I understand that some local (city/county) public health departments have issued orders specifying that the certification must be signed by a physician, nurse practitioner, or other licensed medical professional practicing under the license of a physician.

- "Disability" is defined as a physical or mental disorder or condition that limits a major life activity and any other condition recognized as a disability under applicable law. "Disability" includes pregnancy, childbirth, or a related medical condition where reasonable accommodation is medically advisable.
Please provide any additional information that you think may be helpful in processing your request. Again, do not identify your diagnosis, disability, or other medical information.

While my request is pending, I understand that I must comply with AEG’s COVID prevention policies for unvaccinated or not fully vaccinated individuals as a condition of my employment, including wearing a face covering (mask) while indoors and undergoing at least twice weekly COVID-19 testing. I will also abide by all preventative measures required by my location's public health, environmental health and safety, occupational health, or infection prevention authorities. I understand that I must comply with any additional preventative measures that may be required by AEG because of my particular circumstances or position. If my request is granted, I understand that I will be required to comply with any preventative measures specified by AEG and governmental authorities in my location as a condition of my employment.

I verify the truth and accuracy of the statements in this request form.

Employee Signature: ____________________________
Date: _______________________________________
Date Received: ______________________________
By: _________________________________________
CERTIFICATION FROM HEALTH CARE PROVIDER

AEG requires that its employees be vaccinated against COVID-19 infection as a condition of employment. AEG may grant Exemptions to this requirement based on (a) Medical Exemption due to a Contraindication or Precaution to COVID-19 vaccination recognized by the U.S. Centers for Disease Control and Prevention (CDC) or by the vaccine's manufacturer or (b) Disability, provided that the individual's request for such an Exemption is supported by a certification from their qualified licensed health care provider.

<table>
<thead>
<tr>
<th>Health Care Provider Name:</th>
<th>License Type, # and Issuing State:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Name of Patient:</td>
<td>Date of Birth of Patient:</td>
</tr>
<tr>
<td>Patient’s Employee ID Number:</td>
<td>Health Care Provider Phone/Email:</td>
</tr>
</tbody>
</table>

Physician Supervisor and License # (For a Physician Assistant Working Under a Physician’s License)

Please note the following from the Genetic Information Nondiscrimination Act of 2008 (GINA), which applies to all AEG employees:

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.

Please complete Part A of this form if one or more of the Contraindications or Precautions to COVID-19 vaccination recognized by the CDC or the vaccines' manufacturers apply to this patient. Please complete Part B if this patient has a Disability, as defined below, that makes COVID-19 vaccination inadvisable in your professional opinion. Both sections may be completed if both apply to this patient. Important: Do not identify the patient's diagnosis, disability, or other medical information as this document will be returned to AEG.
Part A: Contraindication or Precaution to COVID-19 Vaccination

I certify that one or more of the Contraindications or Precautions recognized by the CDC or by the vaccines’ manufacturers for each of the currently available COVID-19 vaccines applies to the patient listed above. For that reason, COVID-19 vaccination using any of the currently available COVID-19 vaccines is inadvisable for this patient in my professional opinion. The Contraindication(s) and/or Precaution(s) is/are:

Permanent/Temporary: ________________________

If temporary, the expected end date is:

Part B: Disability That Makes COVID-19 Vaccination Inadvisable

"Disability" is defined as a physical or mental disorder or condition that limits a major life activity and any other condition recognized as a disability under applicable law. "Disability" includes pregnancy, childbirth, or a related medical condition where reasonable accommodation is medically advisable.

I certify that the patient listed above has a Disability, as defined above, that makes COVID-19 vaccination inadvisable in my professional opinion. The patient's disability is: ___Permanent or ___Temporary.

If temporary, the expected end date is: ________________________

Signature of Health Care Provider __________________________ Date ____________________