The purpose of this form is for the applicant (student), to provide information to the University outlining the need to be exempt from the Campus Mask Guidelines due to a medical, disability or mental illness.

The University of Wisconsin Eau Claire recognizes that there are exceptional circumstances, which do warrant consideration of face covering exemption. In meeting this need, we require your verification that the above-named applicant (student at the University of Wisconsin Eau Claire) has a medical need to be exempt from the requirement to wear a face covering while the applicant (student), is in the buildings of the University of Wisconsin Eau Claire. Currently, “all employees, students, and visitors are required to wear a face covering in common areas of University buildings. This includes corridors, lobbies, washrooms, elevators, classrooms, teaching laboratories and meeting rooms, or in any area where physical distancing is a challenge.” Exemptions may occur only with appropriate documentation provided to the University.

TO BE COMPLETED BY ATTENDING HEALTH CARE PRACTITIONER

This form should be completed by an appropriately licensed and trained professional, with knowledge of the applicant’s (student’s), underlying disability, and the capability to assess the applicant’s ability to wear a face covering based on associated functional limitations. This may include: Family Physician, Nurse Practitioner, Psychiatrist, Psychologist, Registered Social Worker etc.

VERIFICATION OF DISABILITY

As the applicant/student’s health care provider, I certify that this applicant/student has a physical or medical impairment that substantially limits a major life activity and that a face covering may cause harm or obstruct breathing which makes it in advisable or impracticable for the applicant (student) to wear (examples include but are not necessarily limited to respiratory impairments, hearing impairments requiring the use of facial/mouth movements, physical impairments that make it difficult to easily wear or remove a face covering, sensory impairments, etc.) because:

Additionally, exemptions will be considered for those that meet one (or more) criteria listed below. Note – you are not required to indicate which category; only to confirm that the applicant (student), does or does not meet the criteria.

- Applicant has severe sensory processing disorders
- Applicant has facial deformities that are incompatible with masking
- Applicant suffers from PTSD and is triggered by face covering
- Applicant has extreme agoraphobia/asphyxia phobia (which is longstanding predating COVID-19)
• Applicant has a cognitive impairment, intellectual deficiency, or autism spectrum disorder for who wearing a mask/face covering will cause severe stress or disorganization
• Applicant is unable to apply or remove face covering without assistance
• Other medical condition(s) which would preclude the applicant from wearing a mask/face covering – **assessor to provide additional details regarding the associated functional limitations:**

Does the applicant (student), have one of the above listed medical disability-related barriers that would preclude them from complying with the requirement of wearing a face covering, in the University of Wisconsin Eau Claire, during their academic studies?

☐ Yes, the applicant (student), meets one of the criteria listed above
☐ No, the applicant (student), does not meet one of the criteria listed above

**HEALTH CARE PRACTITIONER**

Documentation completed by a relative of the applicant (student), will not be accepted due to professional and ethical considerations even when the relative is otherwise qualified to do so. The provider signing this form must be the same person answering the questions on the form above.

Practitioner Name (Please print): Practitioner Signature: Date:
Medical License #
Address/Clinic Name:
Phone Number

**ALL INFORMATION PROVIDED IS CONFIDENTIAL AND WILL BE RETAINED IN THE APPLICANT’S (STUDENT’S) ACADEMIC FILE**

To be completed by committee

☐ This medical exemption is permanent.
☐ This medical exemption is temporary. Duration of temporary exemption _____/_____/_____

Committee Member Signatures:

__________________________________________  ____________________________________________
__________________________________________  ____________________________________________
__________________________________________  ____________________________________________

**Excellence. Our measure, our motto, our goal.**

Office of Equity, Diversity and Inclusion and Student Affairs • Schofield Hall 240