**Request for Medical Exemption from Vaccination**

[Insert brief statement of why policy will be adopted: safety, mandate, etc.]. Due to the importance of vaccination against COVID-19 for community health and our overall mission, exemptions will be granted on legally-required bases only. \_\_\_\_\_\_\_\_\_\_\_\_ (“the Company”) is committed to providing a workplace free of discrimination, which includes a commitment to providing reasonable accommodations based on medical or disability-related impairments or limitations of employees. To request an exemption from the required COVID-19 vaccination based on a medical condition or disability, you must complete Section 1 of the form below and have an appropriate health care provider complete Section 2 of the form and return it to the Human Resources Department. This information on this form will be used only to assess the employee’s reasonable accommodation request. You may attach additional pages as necessary.

**Section 1: To be completed by employee**

|  |  |
| --- | --- |
| Name (print): | Date: |
| Dept.: | Position: |
| Manager: | Work/Cell Phone: |

I verify that the information I am submitting to substantiate my request for exemption from the Company’s vaccination requirement is true and accurate to the best of my knowledge. I further authorize my medical provider to provide the information requested on this form and follow-up/clarifying information related to this request as necessary. I understand that any falsified information can lead to disciplinary action, up to and including termination.

I further understand that the Company is not required to provide this exemption if doing so is unreasonable, would pose a direct threat to myself or others in the workplace, or would create an undue hardship for the Company. I further understand that, if this request is granted, I may be subject to alternative measures to mitigate disease exposure and transmission.

|  |  |
| --- | --- |
| Employee Signature: | Date: |

**Section 2: Medical Certification for Vaccination Exemption**

Employee Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dear Medical Provider,

\_\_\_\_\_\_\_\_\_\_\_\_\_ (the “Company”) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [insert similar language re compelling reason(s) a vaccine mandate is established], unless a permitted exemption applies. The individual named above is seeking an exemption to this policy with respect to this vaccine due to claimed medical contraindications.

Please complete this form to assist the Company in the exemption assessment process.

|  |
| --- |
| **The person named above should not receive the above-indicated vaccine due to:** |
| **This exemption should be:**   * Temporary, expiring on: \_\_/\_\_/\_\_\_\_, or when \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Permanent (“Permanent” exemption requests may still be subject to verification processes on an annual or other regular basis, or as circumstances dictate). |

I certify the above information to be true and accurate, and request exemption from the above-indicated vaccine for the above-named individual. I understand that I may be contacted for additional clarification by an authorized representative for additional clarification and/or confirmation of completion of this form.

|  |  |
| --- | --- |
| Medical Provider Name (print legibly): | |
| Medical Provider Signature:  *(signature stamps are* ***not*** *acceptable)* | Date: |
| Practice Name & Address: | Provider Phone: |

**Section 3: To be completed by the Review Committee** **(attach additional pages if needed)**

Date of initial request: \_\_/\_\_/\_\_\_\_ Date certification received: \_\_/\_\_/\_\_\_\_

Describe the requested exception:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Evaluation of impact (if any): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Outcome of Exemption Request:

* Approved: \_\_/\_\_/\_\_\_\_

If approved, describe specific accommodation details and additional safety or other protective measures that will be required, if any: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Denied due to inability to grant; alternative agreed on: \_\_/\_\_/\_\_\_\_

Describe alternative accommodations available, if any:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date discussed with employee: \_\_/\_\_/\_\_\_\_

Final accommodation agreed on: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Denied due to non-qualifying request: \_\_/\_\_/\_\_\_\_

Describe why request was non-qualifying (ex: not certified, unrelated to a substantial impairment, follow up requests for information not responded to, information provided does not contraindicate vaccination):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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* Denied due to inability to grant; no available or mutually acceptable alternative: \_\_/\_\_/\_\_\_\_

Date discussed with employee: \_\_/\_\_/\_\_\_\_

If no accommodation identified by Company or employee, describe why the vaccine exemption would be unreasonable, pose an undue hardship, or a direct threat:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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If alternative accommodations were proposed but rejected, summarize the proposal(s), identify who made the proposal(s), and the reason(s) for rejection.

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Department/Facility Head: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Human Resources Director: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

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