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| **Request for Accommodation: Medical Exemption from Vaccination** |
| To request an exemption from required vaccinations, please complete Section 1 below and have your medical provider complete Section 2 before returning this form to the human resources department. |
| **Section 1: Employee Information** |
| **Name:** | **Date:** |
| **Department:** | **Position:** |
| **Manager:** | **Work/Cell Phone:** |
| I am requesting a medical exemption from [Company Name]’s mandatory vaccination policy for the following vaccination(s): |
| I verify that the information I am submitting to substantiate my request for exemption from [Company Name]’s vaccination policy is true and accurate to the best of my knowledge. I understand that any falsified information can lead to disciplinary action, up to and including termination. I further understand that [Company Name] is not required to provide this exemption accommodation if doing so would pose a direct threat to myself or others in the workplace or would create an undue hardship for [Company Name]. |
| **Employee Signature:** | **Date:** |
| **Section 2: Medical Certification for Vaccination Exemption** |
| **Employee Name:** |
| [Company Name] requires vaccination against [*insert disease name, such as COVID-19, influenza, etc*.) as a condition of employment. The individual named above is seeking an exemption to this policy due to medical contraindications. Please complete this form to assist [Company Name] in the reasonable accommodation process.  |
| **The person named above should not receive the [*insert disease name*] vaccine due to:**  |
| **This exemption should be:**□ Temporary, expiring on: \_\_/\_\_/\_\_\_\_, or when \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_□ Permanent |
| I certify the above information to be true and accurate, and request exemption from the [insert disease name] vaccination for the above-named individual.  |
| **Medical Provider Name (print):** |
| **Medical Provider Signature:** | **Date:** |
| **Practice Name & Address:** | **Provider Phone:** |
| **Section 3: HR USE ONLY** |
| Date of initial request: | Date certification received:  |
| Accommodation request is: □ Approved Date Approved:Describe specific accommodation details: | Accommodation request is: □DeniedDate Denied: Describe why accommodation is denied:  |