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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: □Denied  Date Denied:  Describe why accommodation is denied: | | | |