# DISABILITY ACCOMODATION REQUEST FORM - COVID-19 VACCINATION

TO REQUEST AN EXEMPTION FROM REQUIRED VACCINATIONS DUE TO A DISABILITY USING THIS FORM:

1. You must complete Part 1 of this form.
2. Your medical provider must complete Part 2 of this form.
3. When both are completed, you must submit the form to [Employer contact].

If you prefer not to complete this form, please contact [Employer contact] to schedule a phone or virtual meeting to make your accommodation request and engage in interactive dialogue.

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| **Part 1 – To Be Completed by Employee** | | | | | |
| **Employee Name** | | **Date of Request** | | | |
|  | |  | | | |
| **Department** | | **Division** | | | |
|  | |  | | | |
| **Position** | **Supervisor** | | | **Phone Number** | |
|  |  | | |  | |
| **Medical or Disability Exception Request** | | | | |
| I am requesting a medical/disability exemption to the mandatory COVID-19 vaccination as required by [Employer]’s vaccination policy. I declare that the information I have provided is true and correct to the best of my knowledge and ability. I understand that any falsified information can lead to disciplinary action, up to and including termination.  I further understand that [Employer] is not required to provide this exemption accommodation if doing so would pose a direct threat to myself or others in the workplace or create an undue hardship for [Employer]. | | | | |
| **Employee Signature** | | | | |
|  | | | | |
| **Print Name** | | | **Date** | |
|  | | |  | |

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| **Part 2 – To be Completed by Employee's Medical Provider** | | | | | | |
| **Employee Name** | | | | | | |
|  | | | | | | |
| **Medical Certification for COVID-19 Vaccine Exception** | | | | | | |
| Dear Medical Provider:  [EMPLOYER] requires vaccination against COVID-19 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 [EMPLOYER] in its reasonable accommodation process. If you have questions about completing this form, please contact [EMPLOYER]’s reasonable accommodation coordinator at [EMAIL AND PHONE HERE]. | | | | | | |
| **Description of the medical condition for which the employee listed above should be excepted from complying with a COVID-19 vaccination requirement:** | | | | | | |
|  | | | | | | |
| **The condition described above is:** |  |  | temporary | |  | long-term |
| If this is a temporary condition or medical circumstance, when it is expected to end or expire (allowing for COVID-19 vaccination to begin after the date you provided): | | | | | | |
| **Medical Provider Name/Title** | | | | | | |
|  | | | | | | |
| **Medical Provider Signature** | | | | **Date** | | |
|  | | | |  | | |

**Human Resources Use Only**

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

Accommodation request APPROVED DENIED (circle one) Date: \_\_/\_\_/\_\_\_\_

If approved, accommodation details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If denied, reason for denial: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_