ADMINISTRATIVE USE ONLY: No.: _____

COVID-19 VACCINATION MEDICAL EXEMPTION REQUEST FORM

To request an exemption from the COVID-19 vaccination requirement of {De-Identified} (the {De-Identified}) for medical reasons, please complete Section 1 below **and have your medical provider complete Section 2** before returning this form by fax to (xxx) xxx-xxxx (please use a cover page) or via e-mail to exemptions@xxx.org.

Section 1

Name (print):	Employee ID No.:
Dept.:	Position:
Manager:	Work/Cell Phone:
Email address:	

I am requesting a medical exemption regarding the COVID-19 vaccination. I am seeking a medical exception that would allow me to be eligible for the same rights as a fully vaccinated employee of the {De-Identified}.

I verify that the information I am submitting to substantiate my request for exemption from the {De-Identified}'s vaccination requirements and policy as it relates to being fully vaccinated 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 the {De-Identified} is not required to provide this accommodation if doing so would pose a direct threat to myself or others in the workplace or create an undue hardship for the {De-Identified}. I authorize the {De-Identified} to contact my healthcare provider if more information is needed to fully evaluate my request.

Employee Signature:	Date:

Section 2 Employee Name: _____

Medical Certification for COVID-19 Vaccination Exemption

Dear Medical Provider,

Federal law requires {De-Identified}, Inc. (the {De-Identified}) employees and other personnel to provide proof of vaccination against COVID-19 absent exemption. The individual named above is seeking an exemption to this law due to medical contraindications to the COVID-19 vaccine. Please complete this form to assist the {De-Identified} in the reasonable accommodation process.

The person named above should not receive the following COVID-19 vaccine(s) due to a medical condition or disability (check all that apply):

☐ Pfizer/BioNTech ☐ Moderna ☐ Janssen (Johnson & Johnson)

This person's medical condition or disability that is a contraindication to the vaccine is:

_____

_____

If the condition is an allergy to the vaccine or vaccine component, I have confirmed the allergy through ☐ allergy testing or ☐ a reported anaphylactic reaction.

This exemption should be:

- ☐ Temporary, expiring on: __/__/____, or when _____.
- ☐ Permanent.

By signing below, I certify that (i) the above information is true and accurate, and (ii) acting with my scope of practice, I recommend exemption from the COVID-19 vaccination requirements for the above-named individual as described above.

Medical Provider Name (print):	
Medical Provide Signature:	Date:
Practice Name & Address:	Provider Phone:

ADMINISTRATIVE USE ONLY

Initial Request Made: __/__/____ Certification Received: __/__/____ Request Number: _____

Request Approved __/__/____ Accommodation details: _____

_____

Request Denied __/__/____ Reason: _____