Medical exemption

To request an exemption from required vaccinations, please complete section 1 below and have your medical provider complete section 2 before returning this form.

**Section 1**

**Employee name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I am requesting a medical exemption from [Employer/Practice Name]’s mandatory vaccination policy for the COVID-19 vaccination.

I verify that the information I am submitting to substantiate my request for exemption from [Employer/Practice 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 [Employer/Practice 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 [Employer/Practice Name].

**Employee signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Section 2**

**Medical Certification for Vaccination Exemption**

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

Dear Medical Provider,

[Employer/Practice Name] 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/Practice 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 COVID-19 vaccination for the above-named individual.

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

**Employer USE ONLY**

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

Accommodation request:

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

Describe specific accommodation details:

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

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

* Denied \_\_/\_\_/\_\_\_\_

Describe why accommodation is denied:

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

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