**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**

|  |  |
| --- | --- |
| Name (print): | Date: |
| Dept.:  | 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dear Medical Provider,

[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 Provide Signature: | Date: |
| Practice Name & Address: | Provider Phone: |

**HR USE ONLY**

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

Accommodation request:

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

Describe specific accommodation details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Describe why accommodation is denied: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_