# 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:

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

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* Denied  \_\_/\_\_/\_\_\_\_

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