Accommodation Request Form — Medical Exemption From COVID-19 Vaccine

SAMPLE's COVID-19 vaccination policy is a demonstration of our commitment to protecting the health and safety of our employees and community at large. SAMPLE is also committed to complying with all applicable laws protecting employees with disabilities and/or medical conditions. Therefore, upon request, SAMPLE will provide an exemption/accommodation for any known medical condition or disability that prevents the employee from receiving a COVID-19 vaccine, provided the requested accommodation is reasonable and does not create an undue hardship for the organization or pose a threat to the health or safety of others in the workplace.

To request an exemption from SAMPLE's COVID-19 vaccination policy, please complete the first section of this form and have a medical provider complete the following section. Upon completion, return this form along with any supporting documentation to [Human Resources]. [Human Resources] will use this information to engage in an interactive process to determine exemption/accommodation eligibility and identify possible reasonable accommodations.

FOR EMPLOYEE

Name	Date of Request

Current Position or Position Applied For	Name of Immediate Supervisor

I hereby verify that the information I am submitting in support of my request for an exemption is accurate, and I understand that any intentional misrepresentation contained within may result in disciplinary action.

Employee Signature	Date

FOR MEDICAL PROVIDER USE ONLY

Employee Name

SAMPLE requires COVID-19 vaccination as part of its COVID-19 vaccination policy. The employee named above is requesting a medical exemption from this vaccination requirement. Please complete the below section of this form to assist in the accommodation process. Please direct any questions to [insert contact] at [insert contact information].

Explain why the person named above should not receive a COVID-19 vaccine:

This exemption should be:

☐ Temporary—Expiration Date:

☐ Permanent

I certify that this information is accurate and that [insert employee name] has the above contraindication. I request a medical exemption from the COVID-19 vaccine requirement for the employee.

Signature of Medical Provider	Date

Name of Medical Provider

Address of Medical Practice

Phone Number

FOR [HUMAN RESOURCES] USE ONLY

☐ Approved—Explain:

☐ Denied—Explain:

Signature of [Human Resources]	Date