Request for Accommodation For Medical Reasons

Facility will consider providing a reasonable accommodation to a qualified employee with a disability if the accommodation would enable the employee to perform the essential functions of the job, unless doing so would pose a direct threat or create an undue hardship for Facility. To request a reasonable accommodation in response to the COVID-19 vaccination requirement, please complete the section below.

Name (print):	Date:
Dept.:	Position:
Manager:	Work/Cell Phone:

Please provide a description of the specific accommodation you are requesting:

_____

_____

_____

Please provide the reason you need an accommodation:

_____

_____

_____

_____

_____

I verify that the information I am submitting to substantiate my request for an accommodation 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.

Employee Signature:	Date:

Medical Certification for Vaccination

Employee Name: ____

Dear Medical Provider,

Pursuant to federal law, _____ (Facility) requires vaccination against COVID-19 as a condition of employment. The individual named above is a Facility employee and is requesting an accommodation in response to this policy due to a medical condition.

Please complete this form to assist Facility in the reasonable accommodation process.

1. Does the patient have a physical or mental impairment(s)?

   Yes _____ No _____

If so, please state the type of impairment(s), including its medical name, the date of diagnosis and a brief description of the condition:

_____

2. Is the patient's physical or mental impairment(s) long-term or permanent?

   Yes _____ No _____

If you answered "Yes" to the previous question, please state the duration or expected duration of the patient's impairment(s).

_____

3. Does the patient's impairment(s) substantially limit any major life activities listed in **Attachment A**?

   Yes _____ No _____

If you answered “Yes” to the previous question, please identify the specific activities in which the patient is limited and state the nature of the limitation, as compared to most people in the general population.

_____

_____

_____

4. Does the patient's impairment(s) substantially limit the operation of any of the major bodily functions listed in **Attachment B**?

Yes _____ No _____

If you answered “Yes” to the previous question, please identify the bodily systems and describe the nature of the limitation imposed by the patient's impairment as compared to most people in the general population.

_____

_____

_____

If you answered “Yes” to the previous questions 1, 3-4, is it your medical opinion that the patient should not receive the COVID-19 vaccine:

Yes _____ No _____

Which COVID-19 vaccine is medically contraindicated for Employee:

____ Pfizer BioNTech mRNA

____ Moderna

____ Johnson & Johnson/Janssen

____ Other: _____

If you answered "Yes" to the previous question, please state the reasons for your medical opinion and the expected duration (permanent or expiring on a certain date)

_____

_____

_____

I certify the above information to be true and accurate

Medical Provider Name (print):	
Provider Type and License No.:	
Medical Provider Signature:	Date:
Practice Name & Address:	Provider Phone:

Attachment A

Caring for oneself
Performing manual tasks
Seeing
Hearing
Eating
Sleeping
Walking
Standing
Sitting
Reaching
Lifting
Bending
Speaking
Breathing
Learning
Reading
Concentrating
Thinking
Communicating
Interacting with Others
Working

Attachment B

Immune system
Special sense organs
Skin
Normal cell growth
Digestive functions
Genitourinary functions
Bowel functions
Bladder functions
Neurological functions
Brain functions
Respiratory functions
Circulatory functions
Cardiovascular functions
Endocrine functions
Hemic functions
Lymphatic functions
Musculoskeletal functions
Reproductive functions

HR USE ONLY

Employee's name: _____

Date of initial request: __/__/____ Date certification received: __/__/____

Interactive discussion date(s) if applicable: _____

Accommodation request:

Approved __/__/____

Describe specific accommodation details:

_____

_____

Denied __/__/____

Describe why accommodation is denied:

_____

_____

_____

Name of HR Representative

_____

Signature

_____

Date