



Request for Accommodation: COVID-19 Vaccination-Medical Exemption

Wellforce is committed to providing equal employment opportunities without regard to any protected status, including individuals with disabilities or medical conditions. When requested, Wellforce will provide an exemption/reasonable accommodation for any known medical condition or disability of a qualified individual which prevents the employee or applicant from receiving a COVID-19 vaccine, provided the requested accommodation does not create an undue hardship for Wellforce or pose a direct threat to the health or safety of patients, others in the workplace, or the requesting employee.

To request an exemption from the required COVID-19 vaccination, please complete the information in section I below and have your medical provider complete section II before returning this form to Occupational Health/Human Resources Department.

Section I

| | |
|-------------------------------|-----------------------------|
| Name (print): Employee ID: | Date: |
| Department: | Manager: |
| Position: | Manager's Work/Cell Phone: |
| Email: | Employee's Work/Cell Phone: |

Section II

Medical Certification for COVID-19 Vaccination Exemption

Dear Physician:

Wellforce requires COVID-19 vaccinations for all students, faculty, staff, providers, volunteers and vendors. A medical exemption from COVID-19 vaccination is allowed for certain recognized contraindications (<https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html>), provided the accommodation does not pose an undue hardship or a direct threat to the health or safety of others and/or the employee.

Please complete the form below. Thank you.

The individual listed above should not be immunized for COVID-19 for the following reasons (please check all that apply):

Severe allergic reaction (e.g. anaphylaxis) after a previous dose of a component of the COVID-19 vaccine.

Immediate allergic reaction of any severity to a previous does or known (diagnosed) allergy to a component of the vaccine. (Vaccine ingredients: <https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html#Appendix-C>)

Which ingredient caused an allergic reaction?

What was the reaction?

Which brand of the COVID-19 vaccine is contraindicated and why?

Other medical reason- Please provide this information in a separate narrative that describes in detail the medical reason (other than allergic reaction) justifying an exemption. *Additional documentation to be attached.*

How long will the medical contraindication last? _____

FOR THE PHYSICIAN certifying the medical exemption request

I certify _____ has the contraindication(s) listed above and request a medical exemption from COVID-19 vaccination.

Physician Signature: _____ Date: _____

Note: signature stamp is not acceptable

Physician medical license No.: _____ NPI No.: _____

FOR THE EMPLOYEE/CONTRACTOR/VOLUNTEER/STUDENT REQUESTING A MEDICAL EXEMPTION

Verification and Accuracy:

I verify that the above information is complete and accurate to the best of my knowledge, and I understand that any intentional misrepresentation contained in this request may result in disciplinary action up to and including termination or suspension. I also understand that my request for an exemption may not be granted if it is not reasonable or if it creates an undue hardship for Wellforce and its entities, or poses a direct threat to the health or safety of others in the workplace and/or myself.

Signature: _____ Date: _____

Print Name: _____

Confidentiality of Information Provided: Requests for exemptions and any documents provided will be kept confidential and shared only with those employees who have a need to know.

Section III: To Be Completed by Human Resources/Decision Maker (additional pages may be attached):

Date of Request: _____ Date of Discussion(s) (if any): _____

Was additional information/documentation requested? _____ Yes _____ No

Was additional information/documentation provided? _____ Yes _____ No

Reasonable accommodation: _____ Approved _____ Denied

Date reasonable accommodation effective: _____

Duration period of reasonable accommodation: _____

If accommodation was denied, please explain the reason:

Alternative accommodations offered (and, if applicable, accepted):

1. _____

2. _____

3. _____

Human Resources Signature: _____ Date: _____