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**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: To be completed by the employee**

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

I am requesting a medical exemption from Katy Trail Community Health’s mandatory COVID-19 vaccination policy.

I verify that the information I am submitting to substantiate my request for exemption from Katy Trail Community Health’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 Katy Trail Community Health 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 Katy Trail Community Health.

|  |  |
| --- | --- |
| Employee Signature: | Date: |

**Section 2: Medical Certification for Vaccination Exemption to be completed by medical provider**

Employee Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dear Medical Provider,

Katy Trail Community Health requires vaccination COVID-19 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 Katy Trail Community Health in the reasonable accommodation process.

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| --- |
| **The person named above should not receive the COVID-19 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 COVID-19 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_