

**COVID-19 VACCINE MEDICAL ACCOMMODATION REQUEST FORM**

Vaccination is a vital tool to reduce the presence and severity of COVID-19 cases in the workplace, in communities, and in the nation as a whole. Juniata has adopted a mandatory vaccination policy to safeguard the health of our employees from the hazard of COVID-19.

Employees may request an exception from this mandatory vaccination policy if the vaccine is medically contraindicated for them or medical necessity requires a delay in vaccination. Employees also may be legally entitled to a reasonable accommodation if they cannot be vaccinated and/or wear a face covering (as otherwise required by this policy) because of a disability.

If you are requesting an accommodation to the COVID-19 vaccination requirement, you must complete Part 1 of this form and submit the form to your healthcare provider. The healthcare provider must complete Part 2 and return the form to you. When both parts of the form are complete, return it to the office of Human Resources.

Human Resources will acknowledge and review the request with appropriate experts and communicate the outcome to the employee in writing within one week from the acknowledgement date of receipt of the request. All such requests will be handled in accordance with applicable laws and regulations. The College may require you to reapply for the approved accommodation annually.

**PART 1 – EMPLOYEE’S MEDICAL ACCOMMODATION REQUEST**

|  |  |
| --- | --- |
| Name (print): | Date of Request: |
| Position: | Department: |
| Supervisor: | Work/Cell Phone: |

I am requesting a medical accommodation to Juniata College’s mandatory COVID-19 vaccination policy.

Please provide the qualifying medical condition that a medical provider considers a contraindication to the COVID-19 vaccine, consistent with CDC guidance (use space below and/or additional sheets if necessary):

(Please ensure that your healthcare provider completes Part 2 of this form.)

**I verify that the information I am submitting to substantiate my request for accommodation from Juniata College’s COVID-19 vaccination policy is true and accurate to the best of my knowledge. I understand that any intentional misrepresentation contained in this request may result in disciplinary action, up to and including termination.**

**I also understand that Juniata College is not required to provide this accommodation if doing so would pose a direct threat to myself or others in the workplace or would create an undue hardship on the College.**

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

**PART 2 – HEALTHCARE PROVIDER CERTIFICATION**

*Note to Provider: Answer, fully and completely, all applicable parts. Please attach supporting documentation/medical documentation as appropriate.*

**Name of Patient:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient should not be immunized for COVID-19 for the following reasons(s): (Please be as specific as possible including the medical condition that is a contraindication for the COVID-19 vaccine consistent with CDC guidance and the duration of the qualifying medical condition.)

I certify that patient has the above contraindication and recommend that they not receive the COVID-19 vaccination as a result of the above contraindication.

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Healthcare Provider’s Name (please print) Specialty

Street Address

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

City, State, Zip Phone Number

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

Healthcare Provider’s Signature Date

*The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of employees or their family members. In order to comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. “Genetic information,” as defined by GINA, includes an individual’s family medical history, the results of an individual’s or family member’s genetic tests, the fact that an individual or an individual’s family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual’s family member or an embryo lawfully held by an individual family member receiving assistive reproductive services.*

**HUMAN RESOURCES USE ONLY**

Date received: \_\_/\_\_/\_\_\_\_ Date Acknowledged: \_\_/\_\_/\_\_\_\_

Date any additional documentation received: \_\_/ \_\_/ \_\_\_

Accommodation request:

* Approved \_\_/\_\_/\_\_\_\_

Describe specific accommodation details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Denied \_\_/\_\_/\_\_\_\_

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

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Signature of staff processing request