Ortonville Area Health Services

Fairway View Senior Communities

REQUEST FOR ACCOMMODATION
MEDICAL EXEMPTION FROM VACCINATION

You have the right to request a medical exemption from the Employer's Vaccine Mandate Policy ("Mandate Policy") if such medical condition qualifies as a disability under the Americans with Disabilities Act ("ADA"). You can request a reasonable accommodation pursuant to the ADA under the Employer's general policies and procedures or you can utilize this form, which has been tailored to the Mandate Policy for convenience.

To request an exemption from the Mandate Policy for a medical condition, please complete Section 1 below and have your medical provider complete Section 2 before returning this form to your manager or Human Resources. The medical provider must be your treating MD, DO, PA, or NP.

Section 1: To Be Completed by Employee

Name: _____ Date: _____

Department: _____ Position: _____

Manager: _____ Work/Cell Phone: _____

I am requesting a medical exemption from the Mandate Policy for the following vaccination(s):

_____

_____

I verify the information I am submitting to substantiate my request for exemption from the Mandate Policy is true, accurate, and complete 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 my Employer is not required to provide this exemption if there is no reasonable accommodation or if granting the exemption would pose a direct threat to myself or others in the workplace or create an undue hardship for my Employer. I understand that my Employer has a duty to protect the workplace's safety, and in granting exemptions or accommodations, my Employer has to continue minimizing the risk of transmission of infectious and communicable diseases for all persons, including high-risk persons, within the workplace.

I also understand even if Employer grants the medical exemption, it may be conditioned upon my compliance with other requirements and alternative accommodations, and my failure to so comply will result in a revocation of this exemption. Finally, I understand that my Employer at all times reserves the right to revoke or modify any medical exemption granted if the legal standards change and/or if the Employer determines that the alternative accommodations can no longer be supported either for financial or safety reasons.

_____ _____

Employee Signature Date

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Section 2: To Be Completed by Employee's Medical Provider

Medical Certification for Vaccination Exemption

Employee Name: _____

Dear Medical Provider,

_____ requires vaccination against 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 _____ in the reasonable accommodation process.

The person named above should not receive the following vaccine(s): (if COVID-19 vaccine, specifically identify each such vaccine, *i.e.*, Johnson & Johnson, Moderna, Pfizer):
This vaccine is contraindicated for the person named above for all the following medical reasons (including description of medical condition):
This exemption should be: ☐ Temporary, expiring on: ___/___/_____, or when _____ ☐ Permanent

I certify that the above vaccine is clinically contraindicated to the above-named person. I certify the above information to be true, complete, and accurate. I also certify that I am not related to the above-named person.

Medical Provider Name (print):	
Medical Provider Signature:	Date:
Practice Name & Address:	Provider Phone:

Section 3: To Be Completed by Employer

Date of initial request: ___/___/_____ Date certification received: ___/___/____

Accommodation Request:

☐ Approved ___/___/____
Describe specific accommodation details and alternative requirements: _____

_____

_____

_____

☐ Denied: ___/___/____
Describe why accommodation is denied: _____

_____

_____

_____

Date Communicated to Employee: _____

Immediate Supervisor: _____ Date: _____

Administrator: _____ Date: _____