

## Request for Religious Exemption for Non-Employee

Please Reference Information at <https://oahs.us/about/covid-vaccine-policies>

*Please note this communication and these options were drafted based off what we know and have decided as of November 15<sup>th</sup>, 2021. Please know this may change with little or no notice.*

Hello Business Associate and Non-Employee,

We are pleased to share that Ortonville Area Health Services and Fairway View Senior Communities is granting Business Associate(s)/Non-Employees the option of seeking a Medical or Religious Exemption related to the **CMS COVID-19 Health Care Staff Vaccination Interim Final Rule** issued on November 4<sup>th</sup>, 2021. This applies to employees and non-employees at over 76,000 healthcare facilities in the United States including OAHS & FWV.

The rule will be enforced on December 5<sup>th</sup>. By December 5<sup>th</sup> Employees and Non-Employees who this rule applies to will need to provide either A) proof that they have been fully vaccinated...or.... B) proof that they have been partially vaccinated and then become fully vaccinated by January 4<sup>th</sup>, 2022...or...C) apply for and receive a medical or religious exemption. Non-Employee who are not in compliance on December 5<sup>th</sup> need to be re-assigned from OAHS/FWV

As of November 15<sup>th</sup> we are allowing Non-Employees who choose not to vaccinate and believe they qualify for a medical or religious exemption to do one of the following:

**Option A:** The Business Associate/Employer of the Non-Employee may setup a process for medical or religious exemptions and carry out their own review and determination of exemptions. For this option, Business Associate/Employer must email us documentation of their policies, procedures, the determination they made for the medical or religious exemption and a copy of the application for religious exemption assuming they are legally allowed to release this document to OAHS/FWV. We may or may not accept your medical or religious exemption based on the information gathered.

**Option B:** The Business Associate/Employer of the Non-Employee may choose to have the Non-Employee apply for a medical or religious exemption through OAHS/FWV. This application should be submitted by November 26<sup>th</sup> and we believe we can make a determination by December 3<sup>rd</sup>.

**Option C:** Inform us if you are exploring other options that may be compliant with the CMS Interim Final Rule. This is new to all of us.

### Proof of Full or Partial Vaccination

Email proof to [covid19@oahs.us](mailto:covid19@oahs.us) noting the name of your Business, what service you provide to OAHS/FWV, and the name of your employee who you are providing proof for.

### Request for Exemption

Please indicate your preference for Option A or Option B in an email to [covid19@oahs.us](mailto:covid19@oahs.us) nothing the name of your Business, what service you provide to OAHS/FWV, and the name of your employee(s) that serve OAHS/FWV.

### Questions

We invite you to call the OAHS/FWV Leader you work most closely with or you are welcome to call our CEO Dave Rogers at 320.839.4127 or email [david.rogers@oahs.us](mailto:david.rogers@oahs.us)

**RELIGIOUS ACCOMMODATION REQUEST FORM**

**Part 1: To Be Completed by Applicant**

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

Employer: \_\_\_\_\_

Date of Request: \_\_\_\_\_

Immediate Supervisor: \_\_\_\_\_

You have the right to request a reasonable accommodation to a requirement, policy, or practice (“Requirement”) of OAHS/FWV that conflicts with your sincerely held religious belief. Objections based on personal, scientific, or political views are not protected. Please complete this form if you wish to apply for a religious exemption to a Requirement. Your answers do not need to be limited to the spaces below, and you can feel free to attach supplemental answers or information.

1. Please identify the Requirement that conflicts your sincerely held religious observance, practice, or belief? \_\_\_\_\_

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

2. Please describe the nature of your sincerely held religious belief, practice, or observance and explain why it conflicts with the Requirement identified above? \_\_\_\_\_

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

3. What is the accommodation or modification you are requesting? \_\_\_\_\_

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

Length of time the accommodation is needed: \_\_\_\_\_

4. List any alternative accommodations that would eliminate the conflict between the Requirement and your sincerely held religious belief: \_\_\_\_\_

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

I have read and understand Ortonville Area Health Services' policy on religious accommodations, and I understand that personal, scientific, or political views are not protected. By signing below, I promise that my beliefs and practices, which serve as the basis for this request for a religious accommodation, are religious in nature and sincerely held and are not personal, scientific, or political in nature. I understand that OAHS may need to obtain supporting documentation or additional information regarding my religious practice, observance, or belief to further evaluate my request for a religious accommodation. I understand that any falsified information can lead to disciplinary action, up to and including termination.

I understand that the accommodation requested above may not be granted by OAHS if there is no reasonable accommodation and/or the request creates an undue hardship on my Employer. I understand that even if my accommodation is granted, it may be conditioned upon my compliance with other requirements or alternative accommodations, and my failure to so comply will result in a revocation of my religious exemption. Finally, I understand that OAHS at all times reserves the right to revoke or modify any religious exemption granted if the legal standards change and/or if my Employer determines that the alternative accommodations can no longer be supported either for financial or safety reasons.

Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Part 2: To Be Completed By Ortonville Area Health Services or Fairway View Senior Communities**

Accommodation Request:

Approved: \_\_\_/\_\_\_/\_\_\_

If granted, describe specific accommodation details or alternative requirements: \_\_\_\_\_

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

Denied: \_\_\_/\_\_\_/\_\_\_

If not granted, explanation of why: \_\_\_\_\_

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

Date Communicated to Applicant: \_\_\_\_\_

Applicant's Supervisor: \_\_\_\_\_

Date: \_\_\_\_\_

Administrator: \_\_\_\_\_

Date: \_\_\_\_\_