COVID 19 VACCINE REQUIREMENT

VERIFICATION AND ACCOMMODATION REQUEST

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE SUBMITTED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Check all that apply:

**CURRENTLY VACCINATED**: Please check the box if you have been vaccinated for COVID-19. Documentation of your vaccination is required and must be attached to this verification accommodation request.

**RELIGIOUS ACCOMMODATION**: Please check the box if you wish to exercise your right to a religious accommodation. [optional-facilities may require a written statement explaining religious exemption. Keep/ Delete based on facility approach]

The CMS Vaccination Rule permits an exception to the requirement for religious beliefs, observances, or practices (established under Title VII of the Civil Rights Act of 1964). By attesting to this exemption, you acknowledge that your personal and deeply held religious beliefs are in conflict with the requirements of 42 CFR 416, 418, 441, 460,482-486, 491,494.

OPTIONAL

Please describe your sincerely held religious belief and the reason you cannot receive any of the available COVID-19 vaccinations pursuant to 42 CFR 416, 418, 441, 460,482-486, 491,494. Please provide a letter from your religious or spiritual advisor, if applicable.

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**MEDICAL ACCOMMODATION**: Please check the box if you wish to exercise your right to a medical exemption.

Please describe your disability (medical condition) and the reason you cannot receive any of the available COVID 19 vaccinations pursuant to 42 CFR 416, 418, 441, 460,482-486, 491,494. Please provide a letter from your medical provider containing: (1) signature and date of a practitioner acting within their scope of practice that is not the person seeking the exemption; (2) all information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive; (3) recognized clinical reasons for the contraindications; and (4) a statement by the authenticating practitioner recommending that the staff member be exempted from the facility’s COVID-19 vaccination requirements.

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­­­­­­­­­­­­­­­**I verify that the information I am submitting in support of my request for an accommodation 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. I also understand that my request for an accommodation may not be granted if it is not reasonable, if it poses a direct threat to the health and/or safety of others in the workplace and/or to me, or if it creates an undue hardship on the facility.**

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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