National Church Residences
EXCELLENCE THAT TRANSFORMS LIVES

REQUEST FOR MEDICAL ACCOMMODATION
COVID Vaccination
(*New Hire Candidate/Employee Form*)

Please print information below:

New Hire Candidate/Employee Name:_____

E-mail:_____ Personal Phone #:_____

Location/Department:_____ Manager:_____

Physician Name:_____ Physician Phone #:_____

I request an exemption from the COVID vaccination as a medical accommodation and will provide medical documentation to support my request.

Declination of Vaccination:

- I understand that due to my occupational exposure, I may be at risk of acquiring infection. In addition, I may spread airborne infection to residents, other employees, and my family, even if I have no symptoms. This can result in serious infection, particularly in persons at high risk for infection or complications.
- I have received education about the effectiveness of vaccinations as well as the adverse events. I have also been given the opportunity to be vaccinated, at no charge to myself. However, I decline vaccination at this time for medical reasons. I understand that by declining this vaccine, I continue to be at risk of acquiring airborne infection, potentially resulting in transmission to residents/clients and colleagues. If in the future I want to be vaccinated, I can receive vaccination at no charge to me.
- If my accommodation request is approved, I attest that I will follow and maintain proper protocols as defined by Organization policy, CDC, and local Departments of Health. This includes wearing a mask at all times while in any organization property or worksite and any time I am working within close proximity to others as well as following current Organization protocols related to PPE, social distancing, self-screening, testing, and quarantining after travel.

Candidate/Employee Signature: _____ **Date:** _____

Print Name: _____

Summary of Next Steps

1. This request will be completed by the individual requesting a medical accommodation.
2. Individual will submit all initial requests via email to HRConfidential@nationalchurchresidences.org
3. HR will notify individual and hiring manager/supervisor of the decision and/or the proposed accommodation.
4. If you disagree with the decision or proposed accommodation, please contact Human Resources to appeal the decision within 3 business days of decision communication. You may submit additional information to support your exemption request. Additional information may include previously unsubmitted medical documentation.
5. Decision following an appeal will be final.

National Church Residences
EXCELLENCE THAT TRANSFORMS LIVES

REQUEST FOR MEDICAL EXEMPTION FROM COVID VACCINATION
(*Physician Form*)

Please print information below:

New Hire Candidate/Employee Name:_____

Date of Birth: _____/_____/_____

E-mail:_____Personal Phone #:_____

Location/Department:_____Manager:_____

Physician Name:_____Physician Phone #:_____

Dear Physician,

National Church Residences requires vaccination for COVID. The above-named individual is requesting an exemption from this vaccination requirement. A medical exemption from the required vaccinations is allowed for certain recognized contraindications.

Please complete the form below.

The above individual should not be immunized for the following reason:

- ☐ History of previous severe allergic reaction and documented allergy testing to indicate an immediate hypersensitivity reaction to the vaccine or a component of the vaccine (including egg allergies).
- ☐ History of Guillain-Barre Syndrome within six weeks of receiving a previous vaccine. Please provide a detailed narrative that describes the event.
- ☐ Other — Please provide this information in a separate narrative that describes the exception in detail, and if the exception is temporary, when the temporary condition is anticipated to end. These requests will be reviewed on a case-by-case basis and are required to be submitted annually.

I attest that I have a physician-patient relationship with _____ and further
(PRINT INDIVIDUAL NAME)
certify that they have the above contraindication and request a medical exemption from the COVID vaccination.

Physician Signature:_____ Date:_____
(Note: THIS IS A MEDICAL-LEGAL DOCUMENT; NO STAMP SIGNATURE)

Physician Medical License No.:_____

PLEASE FAX OR EMAIL THIS TO
HUMAN RESOURCES
National Church Residences
CONFIDENTIAL FAX: (614) 441-8909
EMAIL: Benefits@nationalchurchresidences.org

DESIGNATED OFFICE USE ONLY:
Medical Exception Received on:___/___/___ Receiving Staff Signature:_____