Olivier | VanDyk INSURANCE

REQUEST FOR MEDICAL EXEMPTION/ACCOMMODATION RELATED TO COVID-19 VACCINE

This framework is applicable to flu shots and other employer-mandated vaccines. Thus, the references to COVID-19 may be revised to encompass any other vaccinations that the employer requires.

_____ is committed to providing equal employment opportunities without regard to any protected status and a work environment that is free of unlawful harassment, discrimination, and retaliation. As such, the Company is committed to complying with all laws protecting individuals with disabilities or medical conditions. When requested, the Company will provide an exemption/reasonable accommodation for any known medical condition or disability of a qualified individual which prevents the employee from receiving a COVID-19 vaccine, provided the requested accommodation is reasonable and does not create an undue hardship for the Company and/or pose a direct threat to the health or safety of others in the workplace and/or to the requesting employee. To request an Exemption/Accommodation related to the Company's COVID-19 vaccination policy, please complete Part 1 of this form, have your healthcare provider complete Part 2 (the certification portion), and return them to Human Resources. This information will be used by Human Resources or other appropriate personnel to engage in an interactive process to determine whether an employee is eligible for such exemption/accommodation and if so, to determine the reasonable accommodations which can be provided that would enable the employee to perform the essential functions of their position without posing a threat of harm to self or others. If an employee refuses to provide such information, the employee's refusal may impact the Company's ability to adequately understand the employee's request or to effectively engage in the interactive process to identify possible accommodations.

Medical exemptions/accommodations for the COVID-19 vaccine will be considered if the employee provides a written certification by a licensed, treating medical provider [a physician (MD or DO), nurse practitioner (NP), or physician's assistant (PA)], of one of the following:

_01 The applicable CDC contraindication for the COVID-19 vaccine, or

_02 The applicable contraindication found in the manufacturer's package insert for the COVID-19 vaccine, or

_03 A statement that the physical condition of the person or medical circumstances relating to the person are such that immunization is not considered safe, indicating the specific nature and probable duration of the medical condition or circumstances that contraindicate immunization with the COVID-19 vaccine.

PART 1 – TO BE COMPLETED BY EMPLOYEE:

Name: _____

Date of Request: _____

Verification and Accuracy

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 Company.

Signature:_____

Date: _____

Print Name: _____

Olivier | VanDyk INSURANCE

PART 2 – TO BE COMPLETED BY EMPLOYEE'S MEDICAL PROVIDER:

Company Name:_____

Employee Name:_____

Attention Medical Provider:_____

_____ requires a COVID-19 vaccination as a condition of employment. The abovenamed employee is requesting an exemption from this vaccination requirement. A medical exemption from the COVID-19 vaccination may be allowed for certain recognized contraindications.

Please complete the form below. Should you have any questions, please contact _____ at _____. Thank you.

The above person should not be immunized for COVID-19 for the following reasons (Please check all that apply.):

☐ History of previous allergic reaction to indicate an immediate hypersensitivity reaction to a component of the vaccine.

☐ The physical condition of the person or medical circumstances relating to the person are such that immunization is not considered safe. Please indicate the specific nature and probable duration of the medical condition or circumstances that contraindicate immunization with the COVID-19 vaccine.

☐ Other – Please provide this information in a separate narrative that describes the exemption in detail.

I certify that _____ has the above contraindication and request a medical exemption from the COVID-19 vaccination.

Medical Provider Signature: _____

Date: _____

Print Name: _____

Address: _____

_____

Phone number: _____

PART 3 – TO BE COMPLETED BY HUMAN RESOURCES REPRESENTATIVE

Date this Request Form Received in Human Resources: _____

Interactive Discussion Date(s) if applicable: _____

Exemption/Accommodation granted? _____Yes _____ No

Describe Exemption/Accommodation: _____

If Exemption/Accommodation granted, list required alternative safety precautions

required: _____

If Exemption/Accommodation not granted, explain why: _____
_____
_____
_____
_____

Name of Representative: _____

Signature of Representative: _____

Date: _____