Community Health Network

Request for Medical Exemption from COVID-19 Vaccination

Instructions for Completing This Form

Consistent with the Americans with Disabilities Act (ADA) and any applicable state or local law and Community Health Network's ("CHNw") Americans with Disability Act Accommodation Policy/ Mandatory COVID-19 Vaccination Policy, CHNw will provide a reasonable accommodation to a qualified caregiver with a disability, unless doing so would pose an undue hardship or a direct threat to the caregivers or others in the workplace.

If you believe you need an accommodation relating to the COVID-19 vaccine, you are responsible for requesting a reasonable accommodation from the Employee Health Department. Although you may make an accommodation request orally or in writing, CHNw encourages caregivers to make their requests in writing using this Request for Accommodation under the ADA form. Please submit the completed form (including the Medical Certification for Vaccination Accommodation) to the Employee Health Department at **covidvaccine@eCommunity.com**

as soon as possible after your need for an accommodation is known. If you need extra space to complete this form, please attach additional pages.

After receiving this form, the Employee Health Department will submit it to the exemption committee for review. If additional information is needed to assess your request, you will be contacted. It is important for you and CHNw to engage in this interactive process together, so please be sure to respond to any communications you receive from the Employee Health Department relating to this request. Employee Health will contact you after your request has been evaluated by the exemption committee and a decision made. The committee evaluates request generally on a weekly basis.

As stated in CHNw's Americans with Disability Act Accommodation Policy, CHNw prohibits retaliation against any individual for requesting a disability accommodation in good faith.

If you have any questions about this form or the status of any accommodation request, or if you need assistance with filling out this form or making a request, please contact the Employee Health Department. For more information, see CHNw's Americans with Disability Act Accommodation Policy/ Mandatory COVID-19 Vaccination Policy located via PolicyStat on inComm.

To request an exemption from the COVID-19 Vaccine, please complete section 1 below and have your medical provider complete section 2 before returning this form to the Employee Health Department.

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Notice to Employee and Health Care Provider: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA from requesting or requiring genetic information of employees or their family members, except as specifically allowed by this law. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. Genetic information does not include information related to a caregiver's manifested illness or disease.

In order to comply with this law, we ask that you not provide any genetic information to the CHNw when responding to this request. We appreciate your cooperation in assisting us to avoid any unnecessary and inadvertent disclosure of genetic information to CHNw.

Section 1: To be completed by Caregiver

Name (print):	Date of Birth:
Location:	Role:
Manager/Supervisor:	Work/Cell Phone:

I am requesting a medical accommodation under CHNw's Mandatory COVID-19 Vaccination Policy.

Accommodation requested:

____

____

I verify that the information I am submitting to substantiate my request for accommodation under CHNw's Mandatory COVID-19 Vaccination Policy is true and accurate 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 CHNw is not required to provide this accommodation if doing so would pose a direct threat to myself or others in the workplace or would create an undue hardship for CHNw.

I understand that this Authorization will enable the release of the information concerning my medical denial of the vaccination to my Manager/Supervisor consistent with COVID-19 Vaccination Policy. Additionally, I understand that once this information has been released pursuant to this Authorization, it may no longer be protected by Federal and/or State law/regulations. I may request a copy of my signed Authorization if desired.

I understand that I may revoke this Authorization at any time except to the extent that prior action has been taken in reliance on this Authorization. This Authorization will expire when I am no longer employed by Community Health Network, Inc. or any of its affiliated entities if I do not cancel it in writing prior to the expiration date. I understand that if I wants to cancel/revoke this Authorization, I must mail, fax or bring a letter in person to the Employee Health Department where I turned in my medical denial of the vaccination stating that I want to cancel this Authorization.

Caregiver Signature:	Date:

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Section 2: To be completed medical provider

Medical Certification for Vaccination Accommodation

Caregiver Name: ____________________________________ Caregiver DOB: ___________________

Dear Medical Provider,
As a patient safety initiative, Community Health Network, Inc. ("CHNw") requires COVID-19 vaccinations for all of its employees, students, volunteers, contractors, vendors and providers (collectively referred to as "caregivers"). The COVID-19 vaccination has been recommended for healthcare workers and has been shown, in study settings, to be effective in protecting patients. Your patient is requesting to be exempt from this vaccination. **Medical exemption from COVID-19 vaccination are allowed for recognized contraindications which can be found by visiting the following link:** https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html. Vaccination is required as a condition of employment for all caregivers. The individual named above is seeking an accommodation due to medical contraindications.

Please complete this form to assist CHNw in the reasonable accommodation process. Before completing this form, please see the GINA notice above.

My patient should be exempted from the COVID-19 vaccination requirements based on the following medical contraindications:

- ☐ **A documented history of severe or immediate-type allergic reaction to any ingredient of all currently available COVID-19 vaccine brands. List vaccine ingredient(s) the patient is allergic to.**
  Please check all that apply ☐ J&J/Janssen ☐ Moderna ☐ Pfizer
  Details: ____
- ☐ **A documented history of severe allergy or immediate-type hypersensitivity reaction to a previous COVID-19 vaccination, and also a separate contraindication to all currently available COVID-19 vaccine brands.**
  Please check all that apply ☐ J&J/Janssen ☐ Moderna ☐ Pfizer
  Details: ____
- ☐ **For the J&J/Janssen vaccine: A history of specific heparin allergy known as heparin-induced thrombocytopenia (HIT) may be a contraindication or reason to defer the vaccination.**
  Details: ____

☐ **Other – medical condition that requires the patient to not receive the vaccination or delay until a future date.**
Please check all that apply ☐ J&J/Janssen ☐ Moderna ☐ Pfizer
Details: ____

Note: The following conditions are NOT considered medical contraindications to COVID-19 vaccination:

- **A history of allergy or anaphylaxis to foods, antibiotics, other oral medications, pets, venom, other environmental allergies or non-COVID vaccines.**
- **Sore arm, local reaction or subsequent upper respiratory tract infection.**

Clarification from the requesting caregiver and/or their provider may be requested in writing or by phone.

I certify the above information to be true and accurate, and request accommodation for the COVID-19 vaccination re8quirements for the above-named individual.

Medical Provider Name (print):	
Medical Provide Signature (Stamps not Accepted):	Date:
Practice Name & Address:	Provider Phone:

I understand that this Authorization will enable the release of the information concerning my medical denial of the vaccination to my Manager/Supervisor consistent with Caregiver Vaccination Policy. Additionally, I understand that once this information has been released pursuant to this Authorization, it may no longer be protected by Federal and/or State law/regulations. I may request a copy of my signed Authorization if desired.

I understand that I may revoke this Authorization at any time except to the extent that prior action has been taken in reliance on this Authorization. This Authorization will expire when I am no longer employed by Community Health Network, Inc. or any of its affiliated entities if I do not cancel it in writing prior to the expiration date. I understand that if I wants to cancel/revoke

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Caregiver Signature:	Date:

EMPLOYEE HEALTH DEPARTMENT USE ONLY

Date of initial request: __/__/____ Date certification received: __/__/____

Accommodation request:

☐ Approved __/__/____
Describe specific accommodation details:
____

☐ Denied __/__/____
Describe why accommodation is denied:
____

Name of Employee Health Representative: ______________________________

Signature of Employee Health Representative: _____________________________________

Date: ___________________________

Please scan the completed form to covidvaccine@eCommunity.com.