REQUEST FOR ACCOMMODATION:
MEDICAL EXEMPTION FROM COVID-19 VACCINATION

Part 2. MEDICAL PROVIDER SECTION

TO BE FILLED OUT BY MEDICAL PROVIDER

Employee Name: ______________________________________

Dear Medical Provider:

Your patient has requested that the Company provide them an exemption/accommodation from receiving the COVID-19 vaccination in the event the vaccine is required in the scope of their employment. The Company is committed to providing a reasonable accommodation to any employee who, because of a disability or qualified medical condition, requests an accommodation exempting the employee from receiving the COVID-19 vaccine so they can perform their essential job functions or otherwise enjoy equal employment opportunities without posing a threat to the health and safety of others.

Please complete this form to assist the Company in the reasonable accommodation process.

You may attach additional medical information to the forms as needed. These forms must be completed for the accommodation request to be processed.

Methods to return the document:

To the patient: Use a secure sealed envelope

Using a secure e-mail system: jennifer.craig@capitalelectric.com
OR fax directly to Human Resources at: 913-766-0296

Medical Certification for Vaccination Exemption

This section must be filled out by the medical provider only.
Please print clearly and respond to all items. Please be as descriptive as possible (attach additional sheets as necessary).

Name of Patient	
Date of Birth	
Full Name and Title of the Medical Provider who is the specific person treating the patient	
Practice Name & Address	
Telephone Number	
FAX	
EMAIL	

1. Please provide a detailed description of the specific medical circumstances affecting the patient's ability to receive the COVID-19 vaccination.

2. **Restrictions:** Please confirm whether the patient's medical condition/disability and/or treatment prevents the patient from receiving the COVID-19 vaccination.

   Please circle one to confirm: Yes or No

3. **Accommodations:** Please identify accommodation(s) that may assist the patient to perform the essential functions of their job in a manner that will eliminate or reduce the risk the unvaccinated patient poses to the health and safety of others, if any:

4. Is the patient's disability/medical condition **Temporary** or **Permanent**? [Circle one]. If temporary,

   please state: *Start date* ______________ *End Date*______________.

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

Medical Provider Signature: ____

Date: ____

Medical Provider's License Number: ___________________________________State: ________

<u>HR USE ONLY</u>

Date of initial request: ____/____/_______ Date certification received: ____/____/______

Accommodation request:

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

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