PHILIP HEALTH SERVICES

Request for Accommodation:

Medical Exemption from COVID-19 Vaccination or Mask Requirements

To request an exemption from Philip Health Services required COVID-19 vaccination or masking requirements, please complete section 1 below and have your health care provider (MD or DO) complete section 2 before returning this form into Human Resources.

Section 1

Employee Information

Name (print):	Date:
Dept.:	Position:
Manager:	Work/Cell Phone:

___ I am requesting a medical exemption from the Philip Health Services' mandatory COVID-19 vaccination.

___ I am requesting a medical exemption from the Philip Health Services' mandatory mask requirements.

I verify that the information I am submitting to substantiate my request for medical exemption from the Philip Health Services' COVID-19 vaccination and mask requirements 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 Philip Health Services is not required to provide this medical exemption accommodation if doing so would pose a direct threat to myself or others in the workplace or would create an undue hardship for Philip Health Services.

Employee Signature:	Date:

Section 2

Medical Certification for Vaccination or Masking Exemption

Employee Name: _____

Dear Medical Provider,

Philip Health Services requires vaccination against COVID-19 as a condition of employment. Philip Health Services also requires masking if employees are unvaccinated, or in certain other circumstances even if employees are fully vaccinated, as identified in policy. The individual named above is seeking an exemption to this policy due to medical contraindications.

Please complete this form to assist Philip Health Services in the reasonable accommodation process.

The person named above should not receive the COVID-19 vaccine due to:
The person named above should not be required to wear a mask due to: _____ **This exemption should be:** ☐ Temporary, expiring on: __/__/____, or when _____ ☐ Permanent

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

Medical Provider (MD or DO) Name (print):	
Medical Provider Signature:	Date:
Practice Name & Address:	Provider Phone:

HR USE ONLY

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

Accommodation request:

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

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