Request for Accommodation: Medical Exemption from COVID-19 Vaccination Requirements

To request an exemption from the COVID-19 vaccination requirements, please complete section 1 below and have your medical provider complete section 2. Completed and signed form must be submitted to benefits@inframark.com. You will be notified of the decision after the review process.

Section 1 – To be completed by Employee – Employee Information and Acknowledgements

Employee Name (print):	Date:
Department:	Position:
Manager:	Phone:

Please read below and mark "Acknowledged" by initialing each statement to signify that you have read and understand that statement

I am requesting a medical exemption from the COVID vaccine surcharge requirements that would otherwise apply to me under the Inframark health plan on the basis that it is medically inadvisable for me to be vaccinated against COVID-19. **Acknowledged (Initial) _____**

I understand that any falsified information can lead to disciplinary action, up to and including termination. I further understand that Inframark may ask for more information before rendering a decision in order to clarify any parts of the requested exemption. **Acknowledged (Initial) _____**

Inframark encourages employees to receive the COVID-19 vaccine to prevent COVID-19 and its complications, including death. **Acknowledged (Initial) _____**

I am likely to be exposed to the COVID-19 virus through the community or at work. The strains of the COVID-19 virus frequently mutate, which can spread the virus even faster. The elderly are especially at risk; however, the virus has caused serious illness and death in all age groups. The COVID-19 vaccination series (the two-dose vaccine, or one dose of a single dose vaccine) protects employees, clients, vendors, the public and their families from COVID-19 disease, its complications, and death.
Acknowledged (Initial) _____

Due to my occupation, work location, or duties, I may transmit COVID-19 to coworkers, clients, vendors, or the public, as well as to my family and friends, even though I have no symptoms.
Acknowledged (Initial) _____

If I become infected with COVID-19, even when I have no symptoms or when my symptoms are mild, I can spread severe illness to others, particularly to those in workplaces that are high risk for COVID-19 complications, which can result in life-threatening consequences or death.
Acknowledged (Initial) _____

I have received education about the effectiveness of COVID-19 vaccinations, as well as possible adverse events. **Acknowledged (Initial)** _____

I cannot get COVID-19 from the COVID-19 vaccine. **Acknowledged (Initial)** _____

I acknowledge my responsibility to uphold Inframark's values and only request a medical exemption if truly necessary to protect my own health. **Acknowledged (Initial)** _____

Though I have been given the opportunity to be immunized with the COVID-19 vaccine at no charge to myself, I am requesting a medical exemption from fulfilling the COVID-19 vaccine requirements. **Acknowledged (Initial)** _____

_____
Employee Name (print)

_____ _____
Employee Signature Date

Section 2 – To be completed by Medical Provider - Medical Certification for Exemption from COVID-19 Vaccination Requirements

Dear Medical Provider,

The individual named above is seeking an exemption from the COVID-19 vaccine requirements. Please complete this form to assist Inframark in the reasonable accommodation process and **indicate the specific medical condition in relation to the medical exemption request.**

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

Option 1 - Allergy

☐ A documented history of a severe allergic reaction to any component of a COVID-19 vaccine or to a substance that is cross-reactive with a component. Please indicate which of the following vaccines are contraindicated and name the components, by vaccine.

- ☐ Moderna - List the component(s):
- ☐ Pfizer - List the component(s):
- ☐ Janssen/Johnson & Johnson - List the component(s):

Vaccine Ingredients: https://www.cdc.gov/coronavirus/2019-ncov/vaccines/different-vaccines.html

☐ A documented history of a severe allergic reaction after a previous dose of the COVID-19 vaccine. Please indicate to which vaccine the patient had a reaction and the date of the vaccine and reaction.

- ☐ Moderna - Date of Vaccine & Reaction:
- ☐ Pfizer - Date of Vaccine & Reaction:

Option 2 – Physical Condition/Medical Circumstance

☐ The person named above should not receive the COVID-19 vaccine due to a specific medical condition. The specific medical condition, and the reason(s) that medical condition makes it medically inadvisable to take the COVID-19 vaccine, are as follows **(please specify the condition and the reason(s))**:

_____

_____

_____

This exemption should be:

- ☐ Temporary, expiring on: ____/____/____, or when _____
- ☐ Permanent

The person named above has been under my care starting on: ____/____/____

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

_____ _____

Medical Provider Name (print): Date

_____ _____

Medical Provider Signature Medical Provider Specialty

Practice Name & Address:

_____

_____

_____

Phone Number: _____

INFRAMARK USE ONLY:

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

Accommodation request:

☐ Approved ____/____/____

Describe specific accommodation details:

_____

_____

_____

☐ Denied ____/____/____

Describe why accommodation is denied:

_____

_____

_____

Reviewed by:

_____ _____

_____ _____