EVANGELICAL COMMUNITY HOSPITAL
Excellence Every Day.

Request for Accommodation: Medical Exemption from COVID-19 Vaccination

To request an exemption from the COVID-19 Vaccination, please complete Section 1 below and have your medical provider complete Section 2 before returning this form to People & Culture in person or via email to humanresources@evanhospital.com by 5:00pm on November 22, 2021.

Section 1

Name (print):	Employee ID:
Department:	Job Title:
Manager:	Work/Cell Phone:

I am requesting a medical exemption from Evangelical Community Hospital's mandatory COVID-19 vaccination policy as required by the Centers for Medicare & Medicaid Services (CMS) Healthcare Provider Vaccine Mandate.

I verify that the information I am submitting to substantiate my request for exemption from Evangelical Community Hospital's 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 Evangelical is not required to provide this exemption accommodation if doing so would pose a direct threat to myself or others in the workplace or would create an undue hardship for Evangelical.

Employee Signature:	Date:

Section 2

Medical Certification for Vaccination Exemption

Employee Name: _____

Dear Medical Provider,

Evangelical Community Hospital requires vaccination against COVID-19 as a condition of employment as required by the Centers for Medicare & Medicaid Services (CMS) Healthcare Provider Vaccine Mandate. The individual named above is seeking an exemption to this policy due to medical contraindications.

Please complete this form and return to the employee to assist Evangelical in the reasonable accommodation process.

Describe the medical reason(s) the person named above should not receive the COVID-19 vaccine. Identify which of the authorized COVID-19 vaccines are clinically contraindicated for the employee and the recognized clinical reasons for the contraindications.

This exemption should be:

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

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

Medical Provider Name (print):	
Medical Provide Signature:	Date:
Practice Name & Address:	Provider Phone:

PEOPLE AND CULTURE USE ONLY

Date certification received: __/__/____

Accommodation request:

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

Signature of Reviewer: _____