Request for Accommodation
Medical Exemption from the Company's COVID-19 Vaccination Requirement

The Company is committed to providing and maintaining a workplace that is free of known hazards and has implemented a mandatory COVID-19 vaccine policy as the COVID-19 pandemic continues to pose a direct threat to the health and safety of our employees and their families, our visitors, and the community at large.

The COVID-19 vaccination is recommended for the vast majority of people. The Company recognizes that an individual's medical circumstances may raise a contraindication to getting the vaccine, as determined by a health care provider. Employees requesting exemption due to medical contraindication must fully complete this form, provide documentation to support the exemption request, which includes certification from a health care provider. All forms and supporting documentation must be uploaded to the site below and you must select your intent to apply for a Medical Exception form. Required Documents: Request for Medical Exception Form & Medical Certification Form all forms must be uploaded by the employee in the site below.

https://forms.office.com/Pages/ResponsePage.aspx?id=d2oGdqS_A0-2sTEhCwrGantTrn0HiMJKvVOOiG3wUPlURUE4QVBBT08xN09aQlA3VE9TRUVZVlVKTS4u

Question may be directed to Teresa Daniels, Director Human Resources at Human.Resource@CMHRegional.com or 937-382-9281.

The Company reserves its right to request additional information in support of your request for an accommodation and will comply with all applicable laws in determining whether it is able to accommodate your request without undue hardship to the Company of a direct threat to the health and safety of others in the workplace and/or the requesting employee.

EMPLOYEE SECTION

Employee Name (print):	**Department:**
Supervisor Name:	**Job Title:**
Email:	**Employee ID OR 3/4 ID:**
Work/Cell Phone:	

Employee Request for Medical Exemption:

☐ I am requesting an exemption from the Company's mandatory COVID-19 vaccination policy because of my individual medical circumstances that preclude me from receiving this vaccine. I will contact my health care provider and provide it with the attached Medical Certification Form, which I will return to the Company within 15 calendar days of submitting this request. I will let the Company know immediately if for some reason I cannot meet this deadline.

Verification
By signing below, I hereby certify that the statements and information provided above and below and in furtherance of my request for exemption based on my medical contraindication are true and accurate. I understand that any intentional misrepresentation contained in this request may result in disciplinary action, up to and including termination of employment. I understand that my request for accommodation may not be granted if it is not reasonable, if it poses a direct threat to the health and/or safety of myself and/or others in the workplace, or if it creates an undue hardship for CMH Regional Health System.

Employee Signature: _____ **Date:** _____

PRINT Employee's Name:: _____

FOR HR USE ONLY

Date of Initial Request	
Exemption Request Approved or Denied	
Reason Exemption was Approved or Denied	
Date of Employee Notification of Determination	
HR Follow-Up Date (If Any)	
Human Resources Representative Name	