

**Request Form for Medical Exemption/Accommodation
Related to COVID-19 Vaccine**

Please return this form to Human Resources at hr@union.edu.

Part 1: To Be Completed by Employee Requesting Medical Accommodation:

Name: _____

Email: _____

Date of Request: _____

I understand that Union College (the “College”) requires a COVID-19 vaccination as a condition of employment. I hereby certify that I believe that I have a medical/health condition that necessitates an exemption from this vaccination requirement.

I also understand that for my exemption/accommodation request to be considered by the College that the attached Part 2 of this Request Form must be completed and provided by my medical provider and that my request for an exemption/accommodation due to medical/health reasons will not be considered by the College in the absence of a fully completed Medical Provider certification.

Verification

I verify that the information I am submitting in support of my request for an accommodation is complete and accurate to the best of my knowledge and I understand that any misrepresentation contained in this request may result in disciplinary action.

I also understand that my request for an accommodation may not be granted if it is not reasonable, if it poses a direct threat to the health and/or safety of others and/or to me, or if it creates an undue hardship on the College.

I further understand that I may be asked to recertify my request from time to time as determined by the College.

Print Name: _____

Date: _____

Signature: _____

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Part 2: To Be Completed by Employee's Medical Provider

Medical Provider Certification

Employee Name: _____

Employee Address: _____

Employee Date of Birth: _____

Dear Medical Provider:

The above-named individual is employed by Union College. The College requires a COVID-19 vaccination as a condition of employment to protect the safety and well-being of the College community. The above-named employee is requesting an exemption from this vaccination requirement. A medical exemption from the COVID-19 vaccination requirement may be allowed for certain recognized contraindications.

Your input is necessary for the College to consider a request for an exemption to the COVID-19 vaccination requirement. Please supply the information requested below. If you have any questions, please email hr@union.edu.

Is it your medical opinion that the above-named individual should be exempted from the College's COVID-19 vaccination requirement for the individual's safety?

___ Yes ___ No

If you responded "Yes" please identify the specific nature of the medical condition of the person or medical circumstances that is the basis for your opinion.

If you responded "Yes" please indicate the probable duration of the medical condition or circumstances that contraindicate immunization with the COVID-19 vaccine.

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I hereby certify that the above information is accurate and complete to the best of my knowledge.

Medical Provider Signature: _____ **Date:** _____

Print Name: _____

Address: _____

Phone: _____