

COVID-19 Vaccination Medical Exemption Request Form

Please complete this form and submit it to _____. Submission of this form, documentation from your healthcare provider, and the Authorization for Release of Information by Physician form will serve as your request to be exempt from the Requirement for COVID-19 Vaccination for the Commonwealth's Executive Department Employees established by Executive Order 595. This information and any additional documentation provided in support of this request will be treated confidentially and kept separate from your personnel file.

The ADA Coordinator will engage in an interactive process with you to determine whether you are eligible for an exemption/accommodation and if so, will determine what reasonable accommodation can be provided that will enable you to perform the essential functions of your position. A request for accommodation will not be granted if it is unreasonable, if it poses a direct threat to the health and/or safety of others in the workplace and/or to you, the employee, or if it creates an undue hardship.

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|---------------------|--------------------|
| First Name: | Last Name: |
| Employee ID: | Job Title: |
| Department: | Supervisor: |
| Email: | Phone: |

To apply for a MEDICAL EXEMPTION, please verify and document why the vaccine is medically contraindicated, which means that administration of the COVID-19 vaccine to you would likely be detrimental to your health. Documentation from your health care provider supporting this request must be submitted along with this form.

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Please describe the accommodation you seek.

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Please provide any additional information you believe may be of assistance while we review your request for a MEDICAL EXEMPTION from the COVID-19 Vaccination requirement.

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In some cases, the Commonwealth of Massachusetts will need to obtain additional information and/or documentation from your healthcare provider to complete the review of your request. Please complete and attach the CONFIDENTIAL Authorization for Release of Information by Physician to authorize the ADA Coordinator to speak with your healthcare provider.

Employee Certification

I understand that the Commonwealth of Massachusetts requires Executive Department employees to be fully vaccinated for COVID-19. I certify that I have a medical contraindication to the COVID-19 vaccine that I believe necessitates an exemption from this vaccination requirement.

I certify 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 intentional misrepresentation contained in this request may result in disciplinary actions, up to and including termination.

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

Signature

Date

For ADA Coordinator Only:

Date this request was received:

Description of Interactive Process

Include dates of meetings and/or conversations, documentation received, as well as any accommodations offered and whether they were accepted or rejected.

Exemption/Accommodation Granted?

Yes **No**

If granted, describe the accommodation, including any alternative safety precautions required:

If an exemption is not granted, explain why:

Print Name:

Signature

Date