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| **TO:** | **EMPLOYEE NAME** | **EMPLOYEE ID** |
| **EMPLOYEE EMAIL** | |
| **FROM:** | **ISSUING ORGANIZATION** | **ISSUING ORGANIZATION PHONE/EMAIL** |
| **ISSUING Individual** | **ISSUING TITLE** |

On\_\_\_\_\_\_\_\_\_\_\_\_, we received your request, as a reasonable accommodation related to (Company Name) COVID-19 vaccination mandate for employees based on the following reason:

Accommodation based on medical condition

Accommodation based on sincerely held religious belief, practice, or observance

Your request is **INCOMPLETE**.

We requested the following additional information from you on \_\_\_\_\_\_\_\_\_\_, but had not received it as of the time this document was issued. *You have ten (10) business days to submit the requested information.*

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Your request has been **DENIED**.

After engaging in the interactive process with you, we found that your requested accommodation would pose an undue hardship or a direct threat to your health and safety and/or the health and safety of others that cannot be mitigated for the following reason(s): *(You may use additional sheets if necessary.)*

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| **EMPLOYEE NAME** | **EMPLOYEE ID** |

Because your request for an accommodation has been denied, you have until \_\_\_\_\_\_\_\_\_\_  
[*fourteen (14) calendar days from the denial date below*] to submit proof to (Company Name) that you have received your first dose of a COVID-19 vaccine.

This proof of vaccination must include the date that you received the vaccination. You then have until \_\_\_\_\_\_\_\_\_\_ [*eight (8) weeks from the denial date below*] to submit proof to the (Company Name) that you are fully vaccinated.

***If either of the dates above falls on a weekend or holiday, the deadline for providing the required proof is due on the next business day.***

# Until you are fully vaccinated, you may or will be subject to the following safety protocols for unvaccinated employees:

# You may be required to undergo regular COVID-19 testing at a company designated COVID-19 testing location as a condition of continued employment. Unless otherwise required by an applicable public health order, testing frequency is at the discretion of the (Company Name) and will be informed by local, State, and federal laws, regulations and requirements for COVID-.

# You must provide proof of testing and results to Human Resources upon receipt.

# If you have a positive COVID-19 test result, you must immediately remove yourself from the workplace and take all applicable workplace safety measures in accordance with federal, state and local requirements and work location safety protocols. You may not return to work until after you have completed the relevant isolation period for a COVID-19 infection.

**Regardless of test results, you must adhere to all workplace screening requirements and safety protocols when in a company facility or work location and/or when in contact with other employees or members of the public while working.**

You must also comply with the following safety practices applicable to your position (if any):

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| **EMPLOYEE NAME** | **EMPLOYEE ID** |

**REQUEST FOR RECONSIDERATION INFORMATION**

You may request reconsideration of this determination by the Human Resources within ten (10) business days. If you need additional time to submit your request for reconsideration, you may submit a written request for an extension to Human Resources.

Your request for reconsideration or an extension must be submitted *Insert method of how employee can submit request for reconsideration (i.e. email, in-person, call). If you will not be providing the ability to reconsider request, delete this page.*

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| **Issued By:**  **(name and title)** |  |
| **Denial Date** |  |
| **Date Denial Notice was sent to Employee** |  |