|  |  |
| --- | --- |
| **EMPLOYEE NAME** | **EMPLOYEE ID** |
| **JOB TITLE** | **LOCATION** |
| **Organization** | **SUPERVISOR** |
| **PHONE NUMBER** | **EMAIL** |

I am requesting a reasonable accommodation from the (Company Name) COVID-19 Vaccination Policy because I have a medical condition, contraindication, or precaution that prevents me from receiving a COVID-19 vaccine.

I understand that, as part of this request, I must submit a completed ***Healthcare Provider Statement*** from my licensed healthcare provider within ten (10) business days of the date of this request, and that the ***Healthcare Provider Statement*** must be signed by a physician, nurse practitioner, or other licensed medical professional practicing under the license of a physician.

I understand that in the event I cannot submit a completed *Healthcare Provider Statement* within ten (10) business days, I may request an extension in writing from Human Resources.

Please provide any additional information that you think may be helpful in processing your request.

***Do not identify your diagnosis, disability, or other protected health information.***

|  |
| --- |
|  |

EMPLOYEE ACKNOWLEDGEMENT

While my request is pending, I understand that I must comply with the safety practices (e.g., face coverings, regular asymptomatic testing) for unvaccinated or incompletely vaccinated individuals as a condition of my employment. These required safety practices are defined by the Centers for Disease Control and Prevention, the California Department of Public Health, California Department of Industrial Relations, Division of Occupational Safety and Health, Los Angeles County Department of Public Health, and Los Angeles County Code. I also understand that I must comply with any additional safety practices applicable to my circumstances or position.

|  |  |
| --- | --- |
| **EMPLOYEE NAME** | **EMPLOYEE ID** |
| **JOB TITLE** | **Organization** |

If my request is granted, I understand that I will be required to comply with company safety protocols for unvaccinated employees as a condition of my employment.

|  |  |
| --- | --- |
| **Employee Printed Name** |  |
| **Employee Signature** |  |
| **Date** |  |

**FOR COMPANY USE ONLY**

|  |  |
| --- | --- |
| **Date Request Received** |  |
| **Received By / Title** |  |
| **Date Receipt of Acknowledgement was sent to Employee** |  |