**Sample materials for CHCs implementing a COVID vaccine mandate for staff**

*As of 8/20/2021*

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*These templates are based on resources are based on materials prepared by Carolina Health Centers in Greenwood, SC in which they announce and explain their new requirement that all staff be vaccinated against COVID-19. This CHC is applying a two-phase approach which provides staff with roughly 60 days to come into compliance with the requirement or pursue other opportunities.*

# Sample email to CHC staff announcing vaccination requirement and timeline.

*Name of CHC* has a duty to provide and maintain a workplace that is free of known hazards and to safeguard the health of our employees, their families, and the patients and communities we serve.   We know that the risk of transmission, infection, and death from the COVID-19 virus is significantly reduced through vaccination.  We also know that increasing the number of people vaccinated will decrease the potential for future and potentially more concerning variants of the virus to emerge.  Therefore, in support of our commitment to employee health and wellness, and the health of the community, we will be phasing in the following standards related to vaccination against COVID-19:

**PHASE ONE:**

**Effective August 9, 2021**:  New employees must have initiated the vaccination process prior to their start date or initiate vaccination upon onboarding.  Vaccination must be completed 45 days following their start date in order to continue their employment with *CHC.*

**Effective August 16, 2021**:  Vaccination against COVID-19 will become an Employee Health Standard at *CHC*.

* We encourage all unvaccinated employees to initiate vaccination against COVID-19 on or before this date.
* Employees may reach out to Employee Health Coordinator *(give name)* to assist in scheduling their vaccination.
* Notice of vaccination (initiation and completion) must be provided to Employee Health Coordinator *(give name)* who will be responsible for validating the completion of the vaccination process.
* *CHC* will allow for medical and religious exemptions from the COVID-19 vaccine requirement, in accordance with all applicable laws and regulations.
	+ A medical exemption may be requested through *(give name)*, Chief Medical Officer, and a Medical Review Committee has been established to evaluate those requests.
	+ Requests for religious exemptions may be submitted through *(give name)* and will require membership in an established religion that has publicly announced prohibition against their members receiving the COVID-19 vaccine.
	+ Any employee that received a medical or religious exemption will be subject to weekly COVID-19 PCR testing.
* Any employee that has not received a medical or religious exemption and is unwilling to comply with the COVID-19 vaccine requirement will be subject to weekly COVID-19 PCR testing.  Weekly testing of unvaccinated employees will be the standard at any time local infection rates are elevated.

**PHASE TWO:**

**October 31, 2021:**  As of this date vaccination against COVID-19 will become a Condition of Employment for all *CHC* employees excluding those with an approved medical or religious exemption.  Weekly testing of exempt employees will be the standard at any time local infection rates are elevated.

In closing, we value all our employees and certainly hope that nobody will choose to leave due to this Employee Health Standard. We are hoping that providing this schedule for phasing in the COVID-19 vaccination as a condition of employment allows everyone time to address any questions and concerns that have thus far prevented you from becoming vaccinated. Please reach out to *CMO* or any member of the leadership team and we will be happy to provide you with resource material or put you in touch with other medical professionals who may help you in making this important decision.

# FAQs on COVID-19 Vaccination as a Condition of Employment

**Does *CHC* plan to continue paying the $300 Employee Wellness Incentive to employees who complete the vaccination process?**

As previously announced, up until October 31, 2021 any employee who provides documentation verifying that they are fully vaccinated will receive a $300 Employee Wellness Incentive.  Evidence of being fully vaccinated should be submitted to Employee Health Coordinator, *give name*.   This Wellness Incentive will expire on October 31, 2021 when vaccination against COVID-19 becomes a condition of employment.

**If an individual isn't vaccinated by October 31st and is not exempt, does that mean they can no longer be employed with CHC?**

Yes.  Once COVID-19 vaccination becomes a condition of employment (October 31st), an employee who chooses not to be vaccinated against COVID-19 and has no medical or religious exemption would not be meeting that condition of employment and therefore would not be eligible for continued employment with *CHC*.  We hope no one makes that choice, which is why we are allowing over 60-days for people to make their decision about vaccination.

**Is there something I can sign stating that I didn’t want the vaccine and only got vaccinated to stay employed?**

We are not forcing anyone to get vaccinated against their will.  In good conscience as a health care organization, we are implementing a policy where vaccination is a condition of employment.  If an employee is not willing to become vaccinated and does not consent to that vaccination of their own free will, that is their choice.  However, the consequence of that choice is that they are no longer eligible to remain employed.  Given that, we would not allow an employee to sign a statement indicating that they were vaccinated against their will.

**If an employee is terminated for not being vaccinated, do they qualify for unemployment?**

It is important to clarify that an employee who chooses not to be vaccinated and does not qualify for a medical or religious exemption is choosing not to fulfill a condition of employment.  Therefore, the employee is not being terminated; rather, the employee is choosing not to fulfill the requirements for employment and are voluntarily relinquishing their ability to remain employed at CHC.  An employee may file for unemployment anytime they separate from an employer.  Determination of eligibility will be made by the South Carolina Department of Employment and Workforce.

**If an employee resigns because they are not willing to get vaccinated, can they ever be rehired?**

Like any employee in good standing who voluntarily separates from *CHC* and works a two-week notice, you would be eligible for rehire; however, eligibility for rehire does not guarantee reemployment or priority consideration in the hiring process.  If rehired, like all new employees, vaccination against COVID-19 would be a condition of employment.

**If a staff member chooses to give notice, will they receive a payout of their annual leave if they complete that notice?**

Consistent with *CHC*’s employment policies, an employee who voluntarily terminates their employment and works the required notice will be eligible for a pay out of accrued annual leave up to the maximum hours allowable.

**If a staff member has "natural immunity" as defined by the CDC is that acceptable in place of the vaccine until they are no longer naturally creating antibodies?**

No. Studies have shown that those who had COVID early on are at higher risk of hospitalization and death. Vaccination is still recommended. The more recently you acquired COVID-19 infection, the less chance of hospitalization or death, but the best overall protection is previous infection with COVID **plus** the COVID vaccine.

**Will students and others who do rotations in our practices be required to be vaccinated against COVID-19?**

It is our expectation that individuals coming into any of our locations for educational experience would be vaccinated against COVID-19.  This will be a consideration when applications are submitted to Human Resources.

**Can you clarify the weekly testing requirement for those who choose not to become vaccinated or who receive medical or religious exemptions?**

First, we would like to clarify that the weekly testing requirement would be a PCR test, not an antigen test.  Beginning August 16th and up until the time when being fully vaccinated against COVID-19 becomes a condition of employment (October 31st) the weekly testing requirement applies to all unvaccinated individuals including those who have requested or received medical or religious exemption.  Beginning November 1st, when vaccination is a condition of employment, the weekly PCR testing will be required for those who are unvaccinated due to a medical or religious exemption only when local infection rates are elevated.

**Who can I hold responsible if I have side effects from the vaccine that require medical treatment?**

All vaccines, prescription medication, OTC medicines, dietary supplements, and even some foods may result in unexpected side effects; however, through informed consent and personal choice, absent any negligence on the part of another party, an individual assumes that risk.  There is no one that will be held responsible if you have an unexpected side effect.  If a reaction to the vaccine required medical treatment, that cost could be processed through your insurance like any other qualifying medical expenses.

**If a staff member is fully vaccinated and later develops COVID, will they qualify for FFCRA leave or will they have to use their sick time? Or can they take it without pay?**

A vaccinated person who becomes infected with COVID-19 would be eligible to apply for emergency medical leave under the FFCRA.  However, the FFCRA is scheduled to expire on September 31, 2021, after which employees may use any accrued paid time off – sick, annual, or floating holidays.  If the employee has no remaining paid leave available, they may request leave without pay through their supervisor.

**As staff are getting vaccinated if they experience side effects like fever and flu-like symptoms will they receive FFCRA paid leave?**

Side effects from receiving the COVID-19 vaccination would be a qualifying event for emergency medical leave under the FFRCA.  However, the FFCRA is scheduled to expire on September 31, 2021, after which employees may use any accrued paid time off – sick, annual, or floating holidays.  If the employee has no remaining paid leave available, they may request leave without pay through their supervisor.

**MRNA has been around for 30 years?  Why has it never been used in a vaccine before?**

 mRNA was first investigated as a possible alternative to conventional vaccines in a paper published in 1990. At that time, it wasn’t considered very feasible for a vaccine due to problems with the mRNA breaking down and an inefficient delivery system. It took modern technological developments to make the mRNA stick around long enough in the body for it be usable as a vaccine. Oncology was the first area to start testing mRNA vaccines (vaccines against cancer) back in 2009. 33 clinical studies using mRNA vaccines for oncology have been initiated since 2009. These studies continue but in 2019 most efforts turned towards using the technology for COVID vaccines. Phase I and phase 2 human trials on CMV and flu mRNA vaccines have been going on and/or completed since around 2015. COVID vaccines are the first mRNA vaccines to be produced and tested in large-scale phase III studies.

**Where can *CHC* staff get vaccinated? Will there be a day set up for staff? Will they need to clock out?**

*CHC* wants to make vaccination as convenient as possible for our employees. Efforts are underway to make sure all three vaccines are available so that an employee may receive the vaccine of their choice.  If you choose to be vaccinated on a day you are scheduled to work, you may do so on work time, or “on the clock.”  Finally, there is no cost to the employee for being vaccinated.  For assistance in scheduling your vaccination, please contact Employee Health Coordinator *give name*.

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# Request for Medical Exemption from COVID-19 Vaccination

## Requirements and Instructions

Effective October 31, 2021, vaccination against COVID-19 is a condition of employment with [HEALTH CENTER NAME]. A medical exemption may be granted upon receipt of a completed form (below) and supporting documentation when requested.

* Requests for a medical exemption will be reviewed by and adjudicated by an independent review committee comprised of multidisciplinary [HEALTH CENTER NAME/ACRONYM] providers.
* Priority will be given to the advisory opinions of established and credible medical professional organizations including but not limited to the American Academy of Pediatrics, American Academy of Family Physicians, American College of Obstetrics and Gynecology, Society for Fetal and Maternal Health, and the Centers for Disease Control.
* In those cases where a medical exemption is not consistent with the advisory opinion of an established and credible medical professional organization, the request must be supported by an attestation of need signed and certified by a licensed health care provider, not related to the submitter, and whose specialty is appropriate to the associated condition.
* Documentation related to the medical condition for which any exemption is requested may not be more than 3 months old.
* Medical exemptions expire when the medical condition(s) contraindicating COVID-19 vaccination changes in a manner which permits vaccination. The assigned expiration is at the sole determination of [HEALTH CENTER NAME/ACRONYM].
* While [HEALTH CENTER NAME/ACRONYM] will carefully review all requests for medical exemptions, approval is not guaranteed.

[HEALTH CENTER NAME/ACRONYM] will carefully review each request and determine if the request should be granted. After your request has been reviewed and processed, you will be notified by email if an exemption has been granted or denied. If the approved exemption contains an expiration, you will be expected to complete the requirement at that time. Should the condition continue, or a new vaccination contraindication occur, a new request with updated documentation is required. Decisions are final and not subject to appeal. Individuals whose requests have been denied are permitted to reapply if new documentation and information should become available.

Individuals with an approved exemption may be required to comply with COVID-19 testing and other preventive requirements as specified by [HEALTH CENTER NAME/ACRONYM].

**Medical exemption process:**

* Read the CDC COVID-19 Vaccine Information;
* Complete and sign the following page of this form;
* Have your Licensed Health Care Provider complete the provider section of this form if you feel it will be required;
* Submit the completed documents.

Insert Logo

**[HEALTH CENTER NAME]**

## Request For Medical Exemption from Covid-19 Vaccination

To request an exemption from receiving the COVID-19 vaccination for medical reasons, please complete this form and return to the Chief Medical Officer at [EMAIL]

Employee Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Department/Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Incomplete submissions will not be reviewed. Be sure all forms and documentation are submitted at one time.**

I am requesting an exemption from receiving the COVID 19 vaccine due to the following medical condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please initial next to each of the statements below:

* I request exemption from the COVID-19 vaccination requirements due to my current medical condition described above. I understand and assume the risks of non-vaccination.
* I understand that as I am not vaccinated, to protect my own health, the health of my coworkers and of our patients, I will comply with assigned COVID-19 testing requirements and other preventive guidance.
* I acknowledge that I have read the CDC COVID-19 Vaccine Information.
* I understand that this exemption will expire when the medical condition(s) contraindicating vaccination changes in a manner which permits vaccination, as determined by [HEALTH CENTER NAME/ACRONYM] in reviewing the request.
* If required, I authorize my licensed health care provider to provide [HEALTH CENTER NAME/ACRONYM] with medical information about my medical exemption for the COVID-19 vaccination.
* I certify that the information I have provided in connection with this request is accurate and complete as of the date of this submission. I understand this exemption may be revoked and I may be subject to termination if any of the information I provided in support of this exemption is false.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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# Health Care Provider Attestation for Medical Exemption from COVID-19 Vaccination

**Attention Health Care Provider:**

A condition of employment with [HEALTH CENTER NAME/ACRONYM] is COVID-19 vaccination.
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (insert patient’s name) is requesting a medical exemption from COVID-19 vaccination. A medical exemption may be allowed for certain recognized contraindications. Please certify below the medical reason that your patient should not be vaccinated for COVID-19 by completing this form and attaching available supporting documentation. Information provided on this form will be reviewed in consideration of the exemption request.

By signing and providing further information below, you are attesting that the physical condition of this patient or medical circumstances relating to the individual are such that vaccination is not considered safe. Please state, with sufficient detail for independent medical review, the specific nature and probable duration of the medical condition or circumstances that contraindicate vaccination with the COVID-19 vaccine.

Medical condition or circumstances: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Duration of the medical condition or circumstance and reason why vaccine is contraindicated:

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**Certification**

I certify that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (patient name) has the above contraindication and support the request for a medical exemption from COVID-19 vaccination at [HEALTH CENTER NAME/ACRONYM].

**Provider Information**

Medical Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Provider Specialty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider License Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Practice Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insert Logo

**from COVID-19 Vaccination**

**Request for Religious Exemption**

## Requirements and Instructions

**Effective October 31, 2021, vaccination against COVID-19 is a condition of employment with [HEALTH CENTER NAME AND ACRONYM]. A religious exemption may be granted if the employee (1) holds sincere religious beliefs which are contrary to the practice of vaccination, (2) completes this form, and (3) provides the required documentation to support the exemption request.**

[HEALTH CENTER NAME/ACRONYM] is committed to providing equal employment opportunities without regard to any protected status and a work environment that is free of unlawful harassment, discrimination, and retaliation. As such, [HEALTH CENTER NAME/ACRONYM] is committed to complying with all laws protecting employees’ religious beliefs and practices.

When requested, [HEALTH CENTER NAME/ACRONYM] may provide an exemption/reasonable accommodation for employees’ religious beliefs and practices which prohibit the employee from receiving a COVID-19 vaccine, provided the requested accommodation is reasonable and does not create an undue hardship for [HEALTH CENTER NAME/ACRONYM] or pose a direct threat to the health and/or safety of others in the workplace and/or to the requesting employee.

To request an exemption related to [HEALTH CENTER NAME/ACRONYM]’s COVID-19 vaccination requirements, please complete this form, and return it to Human Resources. This information will be used by Human Resources to engage in an interactive process to determine eligibility for and to identify possible accommodations. If an employee refuses to provide such information, the employee’s refusal may impact [HEALTH CENTER NAME/ACRONYM]’s ability to adequately understand the employee’s request or effectively engage in the interactive process to identify possible accommodations.

While [HEALTH CENTER NAME/ACRONYM] will carefully review all requests for religious exemptions, approval is not guaranteed. [HEALTH CENTER NAME/ACRONYM] will carefully review each request and determine if the request should be granted. After the request has been reviewed and processed, the employee will be notified, in writing, if an exemption has been granted or denied. The decision is final and not subject to appeal. Employees are permitted to reapply if new documentation and information should become available.

Individuals with an approved exemption may be required to comply with COVID-19 testing and other preventive requirements as specified by [HEALTH CENTER NAME/ACRONYM].

Insert Logo

**[HEALTH CENTER NAME AND ACRONYM**

## Request For Religious Exemption from Covid-19 Vaccination

To request an exemption from receiving the COVID-19 vaccination for religious beliefs and practices, please complete this form and return to HR at [INSERT NAME/EMAIL]

Employee Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Department/Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please provide a statement explaining the religious beliefs or practices that necessitate this request for exemption. Please state why the COVID-19 vaccination requirement is contrary to your sincerely held religious beliefs or practices and provide examples of past adherence to these beliefs or practices:

If there is a religious leader or member willing to attest to the premise for this request for a religious exemption, please provide their contact information:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please attach any written materials you may have that describe the religious beliefs or practices and their objections/prohibitions to the COVID-19 vaccine.

**Verification and Accuracy**

I have read and understand [HEALTH CENTER NAME/ACRONYM]’s Requirements and Instructions regarding religious exemption. My religious beliefs and practices which result in this request for a religious exemption are sincerely held. 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 intentional misrepresentation contained in this request may result in disciplinary action up to termination.

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 in the workplace and/or to me, or if it creates an undue hardship on [HEALTH CENTER NAME/ACRONYM].

Name (Print) ­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_