COVID-19 Vaccination
Medical Accommodation Request Form

Instructions: Please refer to the Mandatory Vaccination Policy prior to completing this form. If you are requesting an accommodation for medical reasons that limit your ability to receive the COVID-19 vaccine, you must fill out this form and:

- If you are a job applicant, email this form to HumanResources@thprd.org
- If you are a current THPRD employee, submit the form here.

❑ I am requesting an accommodation on the basis of a diagnosed physical or mental condition that limits my ability to receive the COVID-19 vaccination, as certified by my medical provider below.

Employee Name:	**Employee ID#:**
Department/Location:	**Supervisor Name:**
What accommodation(s) are you requesting? For example, what type of scheduling, equipment, support, or other workplace modification(s) are you requesting?	

Note: Note that information about the workplace modifications you are requesting may need to be shared with your manager, however information about your specific medical condition or disability will be kept confidential.

Employee Signature: _____ Date: _____

Healthcare Provider

Instructions: Your patient, named above, has requested a workplace accommodation due to a medical condition that limits their ability to receive the COVID-19 vaccination. Please provide the information below:

Name of Medical Provider:					
License #:		**State of Issue:**		**Expiration Date:**	
Phone Number:					
Address					

☐ Yes ☐ No I hereby certify that the above-referenced patient cannot receive the COVID-19 vaccine due to a medical or mental impairment or disability as further explained below:

This contraindication or precaution is:	☐ **Permanent**	☐ **Temporary**

If temporary, please provide length of time:
Please identify and describe the disability that is related to the employee's accommodation request.

I hereby certify that I provide regular health care for the patient above, and thecontraindication is well documented in their health record.

Provider Signature: _____ Date: _____