Reasonable Accommodation Request Form

Medical Exemption – COVID-19 Vaccination

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County Executive

Request for Accommodation: Medical Exemption from COVID-19 Vaccination

To request an exemption from required vaccinations, please complete Section 1 below and have your medical provider complete Section 2 before uploading this form into the COVID-19 Employee Vaccination Status Portal or returning this form to your Agency Human Resources Liaison.

Section 1 – Employee Information

Name:	Date:
Agency:	Position:
Manager:	Work/Cell Phone:

I am requesting a medical exemption from Prince George's County Government's mandatory COVID-19 vaccination policy. I understand that I will be required to submit evidence (weekly or at the discretion of the County) of a negative COVID-19 test.

I verify that the information I am submitting to substantiate my request for exemption Prince George's County Government's mandatory COVID-19 vaccination policy is true and accurate to the best of my knowledge. I understand that any falsified information can lead to disciplinary action, up to and including termination.

I further understand that Prince George's County Government is not required to provide this exemption accommodation if doing so would pose a direct threat to myself or others in the workplace or would create an undue hardship for the County.

Employee Signature:	Date:

Please see reverse side for Section 2 – Medical Certification for Vaccination Exemption

Section 2 – Medical Exemption for Vaccination Exemption

Employee Signature:	Date:

Dear Medical Provider,

Prince George's County Government requires vaccination against COVID-19 as a condition of employment. The individual named above is seeking an exemption to this policy due to medical contraindications. Please complete this form to assist Prince George's County Government in the reasonable accommodation process.

The person named above should not receive the COVID-19 vaccine due to:
This exemption should be: ☐ Temporary, expiring on: _____, or when _____ ☐ Permanent

I certify the above information to be true and accurate, and request exemption from the [*insert disease name*] vaccination for the above-named individual.

Medical Provider Name:	
Medical Provide Signature:	Date:
Practice Name & Address:	Provider Phone:

FOR USE BY AGENCY HR LIAISON OR AGENCY ADA COORDINATOR

Date of Initital Request:	Date Certification Received:
☐ Approved	Date:
Describe specific accommodation details:	
☐ Denied	Date:
Describe why accommodation is denied:	