ARKANSAS HOSPICE

HR-46
Request for Medical Exemption/Reasonable Accommodation from Vaccination

Arkansas Hospice is an equal employment opportunity employer and makes all employment decisions without regard to race, color, religion, genetic information, gender, age, national origin, disability, veteran status, or any other characteristic protected by applicable federal or state law. All requests for accommodations are evaluated on a case-by-case basis. Requests for reasonable accommodations may be initiated orally or in writing. To request an exemption from required vaccinations, please complete Section 1 below and have your medical provider complete Section 2 before returning this form to Human Resources. The information collected in this form is maintained in a confidential medical file in compliance with 29 C.F.R. § 1630.14(c)(1) and 29 C.F.R. § 1635.9, as required by the Americans with Disabilities Act and the Genetic Information Nondiscrimination Act.

Section 1:

Name: _____ **Supervisor:** _____

Position: _____

Address: _____

Description of Essential Functions of Position: _____

_____

_____

I am requesting a medical exemption as a reasonable accommodation from Arkansas Hospice's mandatory vaccination policy for the following vaccination(s) due to a disability: _____

_____

_____

EMPLOYEE ACKNOWLEDGEMENT

I verify that the information I am submitting to substantiate my request for exemption from Arkansas Hospice's 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 Arkansas Hospice 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 Arkansas Hospice.

By completing this form, I am authorizing my health care provider to disclose information regarding my medical condition to Arkansas Hospice.

_____ _____

Employee Signature Date

ARKANSAS HOSPICE

Section 2: Medical Certification for Vaccination Exemption
(TO BE COMPLETED BY HEALTH CARE PROVIDER)

Arkansas Hospice requires its employees to receive various vaccinations as a condition of employment. The individual named above is seeking an exemption to this policy due to medical contraindications. Please complete the form below to assist Arkansas Hospice in faithfully completing the interactive, good faith reasonable accommodation process. Limit your response to the medical condition(s) for which the employee is seeking a reasonable accommodation. Your answers should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b).

Health Care Provider Name:_____

Clinic Name & Address:_____

Phone Number:_____ Fax Number: _____

Patient Name: _____

Date & Time of Encounter: _____

A. Questions to help determine whether an employee has a disability.		
For reasonable accommodation under the ADA, an employee has a disability if he or she has an impairment that substantially limits one or more major life activities or a record of such an impairment. The following questions may help determine whether an employee has a disability:		
Does the employee have a physical or mental impairment?	Yes ☐	No ☐
If *yes*, what is the impairment or the nature of the impairment (not the diagnosis)?		
Answer the following question based on what limitations the employee has when his or her condition is in an active state and what limitations the employee would have if no mitigating measures were used. Mitigating measures include things such as medication, medical supplies, equipment, hearing aids, mobility devices, the use of assistive technology, reasonable accommodations or auxiliary aids or services,		

ARKANSAS HOSPICE

prosthetics, learned behavioral or adaptive neurological modifications, psychotherapy, behavioral therapy, and physical therapy. Mitigating measures do not include ordinary eyeglasses or contact lenses.

Does the impairment substantially limit a major life activity?	Yes ☐	No ☐

If *yes*, what major life activity(s) (includes major bodily functions) is/are affected?

☐ Bending	☐ Hearing	☐ Reaching	☐ Speaking	☐ Other: (describe)
☐ Breathing	☐ Interacting With Others	☐ Reading	☐ Standing	
☐ Caring For Self	☐ Learning	☐ Seeing	☐ Thinking	
☐ Concentrating	☐ Lifting	☐ Sitting	☐ Walking	
☐ Eating	☐ Performing Manual Tasks	☐ Sleeping	☐ Working	

Major bodily functions:

☐ Bladder	☐ Digestive	☐ Lymphatic	☐ Reproductive
☐ Bowel	☐ Endocrine	☐ Musculoskeletal	☐ Respiratory
☐ Brain	☐ Genitourinary	☐ Neurological	☐ Special Sense Organs & Skin
☐ Cardiovascular	☐ Hemic	☐ Normal Cell Growth	☐ Other: (describe)
☐ Circulatory	☐ Immune	☐ Operation of an Organ	

B. Questions to help determine whether an accommodation is needed.

An employee with a disability is entitled to an accommodation only when the accommodation is needed because of the disability. The following questions may help determine whether the requested accommodation is needed because of the disability:

In your medical judgment, does the employee require an exemption from Arkansas Hospice's mandatory vaccine policy, which requires the following vaccinations: COVID-19 Vaccine?

Which vaccinations do you believe the employee should be exempted from receiving based on his or her disability?

Are these exemptions permanent?

If you answered "no" above, please list the expected duration of this exemption?

Exemption	*Duration of Exemption*
Exemption	*Duration of Exemption*

ARKANSAS HOSPICE

CERTIFICATION

I, _____ (printed name of healthcare provider), at the date and time above, evaluated the employee named above and, after reviewing the attached job description, have made the determinations set forth in this document under Section 3 based on my professional medical judgment and opinion.

Signature:_____
Date

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

END OF FORM

HR USE ONLY

Date of initial request: __/__/_____ Date certification received: __/__/_____
Accommodation request:

- ☐ Approved __/__/_____

  Describe specific accommodation details:
  _____
  _____

- ☐ Denied __/__/_____
  Describe why accommodation is denied:
  _____
  _____

- ☐ Additional Information Required – Employee notified __/__/_____