CITY OF PHOENIX

HUMAN RESOURCES DEPARTMENT

COVID-19 Vaccination Medical Accomodation Request Form

Date:

To: Physican or Medical Provider

From: City of Phoenix - Human Resources Department

Employee Name:

Job Title:

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 and whether the employee needs accommodation(s) to perform the essential functions of his/her job. The information requested will only be used for these purposes and will be treated as confidential. We are requesting the information be provided by (usually 10 business days of issuance to employee).

In compliance with the Genetic Information Nondiscrimination Act of 2008, please do not include genetic or family history information in your response to this request. Please include only information relating to the employee's current medical condition.

1. **Please identify and describe this person's medical contridiction to receiving a COVID-19 vaccination.**

☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a component of the COVID-19 vaccine. (Please describe response in detail below and contraindication to alternative vaccines)

☐ Immediate allergic reaction of any severity to a previous dose or known (diagnosed) allergy to a component of the vaccine. (Please describe response in detail below and contraindication to alternative vaccines)

☐ Other medical circumstance preventing vaccination with any available COVID-19 vaccine. Please include below:

a) The medical reason justifying an exception in detail, including a description of the physical or mental limitations and probable duration of the medical condition or circumstances that contraindicate immunization with the COVID-19 vaccine.

b) If this is a temporary condition or medical circumstance, when is it expected to end or expire (allowing for COVID-19 vaccination to begin after the date you provided).

2. For medical circumstances preventing vaccination with any COVID-19 vaccine, what recommendations do you have for accommodation?

Health Provider Signature	Date
Health Provider Printed Name	Type of Practice
Address, City, State, Zip Code	Phone number

Healthcare provider please return to the above employee within 10 business days.

EMPLOYEE: Sign below and submit the request to vaccine.request@phoenix.gov.

By signing or typing in my name below, I certify that the information I have provided in this request for exemption is true and accurate. I understand that submitting false information on this request for exemption will subject me to corrective action, up to and including termination of employment.

- approval of this exemption does not mean I am cleared to work without any further accomodations;
- if the exemption is approved, the City will explore and, if possible, implement a reasonable accommodation that will allow me to perform my job;
- accommodations may include continuous masking, frequent PCR testing, additional PPE requirements, and other measures as COVID-19 and business circumstances warrant.

Signature:

Date Submitted: