Medical Exemption from COVID-19 Vaccination Request Form

Complete section 1 below and have your medical provider complete section 2 before returning this form to the human resources department.

Section 1

Employee ID #: _____

Employee Name (print): _____ Date: _____

Dept.: _____Position:_____

Manager: _____ Work/Cell Phone: _____

I am requesting a medical exemption from County College of Morris' mandatory vaccination policy for the COVID-19 vaccination for the following reason(s):_____
_____
_____

I verify that the information I am submitting to substantiate my request for exemption from County College of Morris' 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 County College of Morris 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 County College of Morris.

I understand I must provide weekly COVID-19 PCR tests to HRCOVID@CCCM.EDU showing a negative result. This process will remain in effect until guidelines have been updated.

I give County College of Morris permission to contact my medical provider for clarification, if needed.

Employee Signature: _____ Date: _____

Section 2

Medical Certification for Vaccination Exemption

Employee Name: _____

Dear Medical Provider,

County College of Morris 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 County College of Morris 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 COVID-19 vaccination for the above-named individual.

Medical Provider Name (print): _____

Medical Provide Signature: _____ Date: _____

Practice Name & Address: _____

_____

_____

Phone Number:_____

HR USE ONLY

Date certification received: __/__/____

Date of initial request: __/__/____

Accommodation request:

☐ Approved __/__/____

Describe specific accommodation details:

_____

☐ Denied __/__/____

Describe why accommodation is denied:

_____

_____

_____