INTELLISTAFF MEDICAL

Medical Certification Form – COVID-19
Request for Exemption from Mandatory Vaccination Policy

Employee Name (print): _____ **Date**: _____

Dear Health Care Provider,

The above-named employee (your patient) has disclosed that he/she has a medical impairment(s) that renders him/her unable to comply with the Company's requirement that employees be fully vaccinated (including any recommended boosters) against COVID-19.

Please complete this form in full to assist the Company in the reasonable accommodation process, and return to the above-named employee at your earliest convenience. If the employee works or resides in California, do not disclose any diagnoses without the employee's specific consent.

NOTE: The Genetic Information Nondiscrimination Act of 2008 (GINA) and similar state laws generally prohibit employers and other entities covered by GINA Title II (and similar state laws) from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by law. To comply with applicable law(s), we are asking that you not provide any genetic information or results of genetic tests, as defined by applicable law(s), when responding to this request for medical information. By way of example, "genetic information" (as defined by federal law) 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.

The above-named individual has a medical impairment that renders him/her unable to receive the COVID-19 vaccination.

☐ Yes ☐ No

If you answered "No," do not answer the remaining questions, but complete and sign the "Certification" at the end of this document.

Please describe in detail how the medical impairment(s) renders the employee unable to comply with the Company's requirement that employees be fully vaccinated against COVID-19:

This vaccination exemption should be:

☐ Temporary, expiring on: ____/____/_____, or when _____

☐ Indefinite

Are there accommodations that will reduce or eliminate the threat of injury/harm posed to the employee's own health and/or safety – or the health/safety of others in the workplace – while the employee is at work given that the employee is not fully vaccinated against COVID-19?

☐ Yes ☐ No

If you answered "Yes," please describe <u>all</u> such accommodations in detail and explain how these accommodations will reduce or eliminate the threat:

CERTIFICATION

By signing below, I certify that the answers provided in response to the above questions are based on my own personal knowledge of the relevant medical facts from my own examination of the patient/employee, and/or based on my own review of the relevant medical documentation, and my answers represent my professional medical opinion.

Health Care Provider Name (print):	
Health Care Provider Signature:	Date:
Health Care Practice & Address:	Phone:
Health Care Specialty or Type of Practice:	Fax Number: