



Accommodation Request Form – Medical Exemption COVID-19 Vaccination

Laguna College of Art + Design is committed to complying with all laws that protect qualified individuals with a medical condition. When requested, the company will provide a reasonable accommodation for a medical condition that may interfere with an employee’s ability to receive a COVID-19 vaccination, provided the requested accommodation does not create an undue hardship or pose a direct threat to the health or safety of others in the workplace and/or to the requesting employee. Laguna College of Art + Design is committed to participating in a good faith interactive process with employees to determine whether or not a reasonable accommodation can be made.

To request an exemption from COVID-19 vaccination, please complete section 1 below and have your medical provider complete section 2 before returning this form.

**SECTION 1
TO BE COMPLETED BY EMPLOYEE**

Name:	
Job Title:	
Department:	
Supervisor:	

I am requesting a medical exemption from LCAD’s mandatory vaccination policy for the COVID-19 vaccination.

I verify that the information I am submitting to substantiate my request for exemption from LCAD’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 LCAD 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 LCAD.

Employee Signature:	Date:
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**SECTION 2
Medical Certification for Vaccination Exemption
TO BE COMPLETED BY LICENSED MEDICAL PROFESSIONAL**

Dear Medical Provider,

LCAD 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.



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Please complete this form to assist LCAD in the reasonable accommodation process.

<p>The person named above should not receive the COVID-19 vaccine due to (please list the nature of impairment and reason(s) for conflict with vaccination:</p>
<p>This exemption should be:</p> <p><input type="checkbox"/> Temporary, expiring on: __/__/__, or when _____</p> <p><input type="checkbox"/> Permanent</p>

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:	Provider Phone:

Please return this form to Human Resources.

For Employer Use:

Received By:	
Date:	
Request:	<input type="checkbox"/> Approved <input type="checkbox"/> Denied
Additional Information:	
Description of Accommodation Agreed Upon	