## Employee Information and Request

Employee Name: _____ Employee Number: _____

Position: _____ Department: _____

Phone Number: _____ Email: _____

*Directions*

Please read each paragraph and check the box to acknowledge your understanding and sign below. If you have any questions about the statements or the Exemption Request please ask Human Resources.

- ☐ I am requesting a medical accommodation from the City of Highland Park's COVID-19 Vaccine Policy.
- ☐ I understand that I am responsible for providing any required Medical Information to Human Resources.
- ☐ I understand that I may be required to engage in the interactive process with the City of Highland Park to determine the outcome of my request.
- ☐ I verify that the information I am submitting to substantiate my request for accommodation from the City of Highland Park's COVID-19 Vaccine 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 the City of Highland Park is not required to provide this accommodation if doing so would pose a direct threat to myself or others in the workplace or would create an undue hardship for the City of Highland Park.

_____ _____

Employee Signature Date

## Medical Certification for Vaccination Accommodation Request

Employee Name:_____

Dear Medical Provider,

The City of Highland Park 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 the City of Highland [Company Name] in the reasonable accommodation process.

**The person named above should not receive the COVID-19 vaccine for medical reasons.**

**This exemption should be:**

- ☐ Temporary, expiring on: __/__/____, or when _____.
- ☐ Permanent

I certify the above information to be true and accurate.

| Medical Provider Name (print): | |
|---|---|
| Medical Provide Signature: | Date: |
| Practice Name & Address: | Provider Phone: |