**Volunteer Request for Accommodation: Medical Exemption from Vaccination**

To request an exemption from required vaccinations, please complete **Section 1** below and have your medical provider complete **Section 2** before returning this form to the Chief Executive Officer (CEO) at hr@mannafood.org. Your medical provider must complete Section 2 in order for this request to be considered using the fax 1-301-560-6344.

**Section 1**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of request: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Immediate supervisor (Katie Sayago, Volunteer Manager, or Cheryl Kollin, Community Food Rescue Program Director): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

|  |  |
| --- | --- |
| Volunteer Signature: | Date: |

(For ease of signing this form, you may type your name in the signature line using a cursive font).

**Section 2**

**Medical Certification for Vaccination Exemption**

Volunteer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dear Medical Provider,

Manna Food Center (“Manna”) requires vaccination against COVID-19 as a condition of volunteering. The individual named above is seeking an exemption to this policy due to medical contraindications.

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

|  |
| --- |
| * **The person named above should not receive the COVID-19 vaccine due to:**
* **The person named above does not have any medical restriction that would prevent receipt of the COVID-19 vaccine.**
 |
| **This exemption should be:*** Temporary, expiring on: \_\_/\_\_/\_\_\_\_, or when \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Permanent
 |

I certify the above information to be true and accurate, and I request exemption from the COVID-19 vaccination for the above-named individual. (For ease of signing this form, you may type your name in the signature line using a cursive font).

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