APPENDIX A

REQUEST FOR ACCOMMODATION: MEDICAL EXEMPTION FROM VACCINATION

IN COMPLIANCE WITH EXECUTIVE ORDER NO. 13G
("Protection of Public Health and Safety During COVID-19 Pandemic — Vaccinations Required for State Employees, School Employees and Childcare Facility Staff")

To request an exemption from the COVID-19 vaccination requirement under Executive Order No. 13G ("Order 13G"), please complete Section 1 below and have your medical provider(s) complete Section 2 before returning this form via email to:

Gary Highsmith
Assistant Superintendent for Human Resources and Administration
203.407.2059
covidexemption@hamden.org

All exemption requests will be considered on an individualized, case-by-case basis.

Section 1

Name (print):	Date:
Building:	Position:
Supervisor:	Cell Phone:

Please initial below to confirm you have read and agree with the following statements:

______I am requesting a medical exemption from the COVID-19 vaccination requirement under Order 13G because a **physician, physician's assistant, or advanced practice registered nurse** has determined that the administration of the COVID-19 vaccine is likely to be detrimental to my health, and I believe I am able to perform my essential job functions with a reasonable accommodation that is not an undue burden on Hamden Public Schools (the "school district").

______I understand that under Order 13D, employees who have applied for a medical exemption from the COVID-19 vaccination requirement must provide appropriate supporting documentation upon request, and as such, I may be asked to provide additional supporting documentation. I verify that the information I am hereby submitting to support my request for a medical exemption from the COVID-19 vaccination requirement 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 of my employment.

_____I understand that the school district is not required to provide accommodations, including but not limited to an exemption from the COVID-19 vaccination requirement, if doing so would

pose a direct threat to others or myself in the workplace or would create an undue burden on the school district.

_____I understand that Order 13G directs school districts to implement a policy requiring employees who have not demonstrated proof of full vaccination to submit to weekly COVID-19 testing, and as such, **I must submit to weekly COVID-19 testing if the school district grants my request for a medical exemption from the COVID-19 vaccination requirement**. In addition to such testing requirement under Order 13G, the school district may require unvaccinated employees entering the workplace to follow certain health and safety precautions as communicated to me by the school district, and to take certain other measures as a reasonable accommodation, subject to the requirements of the interactive process, which may include, but are not limited to, the following: wearing a face mask regardless of whether there is a state-imposed mask mandate, working at a social distance from co-workers and students, working a modified shift, accepting a reassignment, participating in contact tracing, quarantining, and/or abiding by restricted access to facilities. I further acknowledge that it is my responsibility to abide by such precautions or other accommodations that may be provided and/or required by the school district in order to provide a safe and healthy workplace for myself and others in the school district.

Employee Signature:	Date:

Medical Certification for Exemption from COVID-19 Vaccination Requirement

Employee Name: ____

Date of Birth: ______________________

I hereby authorize my medical provider(s), _______________________________, to release the information below from my patient file to the __________ Public Schools (the "school district") for the purpose of permitting the school district to (1) assess my request for a medical exemption from the COVID-19 vaccination requirement and (2) determine a reasonable accommodation that is not an undue burden on the school district. I further consent to school officials of the school district communicating with the above-named medical provider(s) in connection with my request for a medical exemption from the COVID-19 vaccination requirement. I understand that such medical provider(s) is authorized to exchange with the school district health/medical information related to my request for a medical exemption from the COVID-19 vaccination requirement. I understand that the purpose of the exchange of such information is to (1) assess my request for a medical exemption from the COVID-19 vaccination requirement and (2) determine a reasonable accommodation that is not an undue burden on the school district. I understand that this authorization will expire on June 30, 2022, unless I revoke this authorization at an earlier time by submitting written notice of the withdrawal of consent.

____________________________________ ________________

Employee Signature Date

Section 2- TO BE COMPLETED BY MEDICAL PROVIDER:

Dear Medical Provider:

In accordance with Executive Order No. 13G ("Protection of Public Health and Safety During COVID-19 Pandemic — Vaccinations Required for State Employees, School Employees and Childcare Facility Staff") ("Order 13D"), the school district requires vaccination against COVID-19 as a condition of employment. The school district employee named above is seeking a medical exemption from the COVID-19 vaccination requirement under Order 13G on the basis that the administration of the COVID-19 vaccine is likely to be detrimental to the employee's health.

Order 13G directs school districts to implement a policy requiring employees who have not demonstrated proof of full vaccination to submit to weekly COVID-19 testing, and as such, the employee will be required to submit to weekly COVID-19 testing if the school district grants the employee's request for a medical exemption from the COVID-19 vaccination requirement. In addition to such testing requirement under Order 13G, the school district may require unvaccinated employees entering the workplace to follow certain health and safety precautions as communicated to the employee by the school district, and to take certain other measures as a reasonable accommodation, which may include, but are not limited to, the following: wearing a face mask regardless of whether there is a state-imposed mask mandate, working at a social distance from co-workers and students, working a modified shift, accepting a reassignment, participating in contact tracing, quarantining, and/or abiding by restricted access to facilities.

Please complete this form for the purpose of permitting the school district to (1) assess the employee's request for a medical exemption from the COVID-19 vaccination requirement and (2) determine a reasonable accommodation that is not an undue burden on the school district.

The employee named above is unable to receive the COVID-19 vaccine because the administration of the COVID-19 vaccine is likely to be detrimental to the employee's health for the following reason(s):
This exemption should be: ☐ Temporary, expiring on: __/__/____, or when ___________________________________ ☐ Permanent
The employee named above is able to implement the following measures as an accommodation: wearing a face mask regardless of whether there is a state-imposed mask mandate, working at a social distance from co-workers and students, working a modified shift, accepting a reassignment, participating in contact tracing, quarantining, and/or abiding by restricted access to facilities. ☐ Yes to all ☐ No to all or the following measure(s): ____ **If you checked "No to all or the following measure(s)," please (1) explain the medical basis for the objection to the proposed accommodation measure(s) and (2) propose alternative measures:**

I certify the above information to be true and accurate, and request exemption from the COVID-19 vaccination requirement for the above-named employee.

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

HR USE ONLY

Date of initial request: __/__/____ Date certification received: __/__/____

- ☐ Approved __/__/____
- ☐ Denied __/__/____

  Describe why request is denied:

  ____

- ☐ Pending __/__/____

  More information is required. Describe what additional information is required.

  ____