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 Volunteers of America (VOA) Carl Gipson Center. Scanned copies of the form may be emailed to Operations Manager Gul Subaykan at gsubaykan@voaww.org.

**Section 1 – To be completed by member**

|  |  |
| --- | --- |
| Name | Date |
| Email Address | Phone |

I am requesting a medical exemption from the VOA’s Carl Gipson Center’s mandatory vaccination policy for the following vaccination(s):

I verify that the information I am submitting to substantiate my request for exemption from VOA Carl Gipson Center’s vaccination policy is true and accurate to the best of my knowledge. I further understand that VOA is not required to provide this exemption accommodation if doing so would pose a direct threat to myself or others in the Carl Gipson Center or would create an undue hardship for VOA.

|  |  |
| --- | --- |
| Signature | Date |

***Continue to Section 2 🡪***

**Section 2 – To be completed by medical provider**

**Medical Certification for Vaccination Exemption**

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

Dear Medical Provider,

VOA’s Carl Gipson Center requires vaccination against COVID-19 as a condition of membership. The individual named above is seeking an exemption to this policy due to medical contraindications. Please complete this form to assist VOA in the reasonable accommodation process.

|  |
| --- |
| **The person named above should not receive the COVID-19 vaccine due to:** |
| **This exemption should be:*** Temporary, expiring on: \_\_\_\_\_\_\_ /\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_ or when \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Permanent
 |

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: |

**Section 3 - CARL GIPSON CENTER STAFF USE ONLY**

Date of initial request: \_\_\_\_\_\_\_ /\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_ Date certification received: \_\_\_\_\_\_\_ /\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_ Accommodation request status:

* Approved (Describe specific accommodation details) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Denied (Describe why accommodation is denied) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_