Employee Request for Medical Exemption from COVID-19 Vaccine Form

To request a medical exemption from the required COVID-19 vaccination, please complete Section 1 below and have your medical provider complete Section 2 before submitting this form to your supervisor.

Section 1:

Name (print):	Position:
Building/Dept.:	Principal/Supervisor:

I am requesting a medical exemption from the COVID-19 vaccination requirement due to my current medical condition. I understand that in the event of an outbreak or threatened outbreak, I may be temporarily excluded or reassigned from District facilities.

I understand I may need to submit a new request for subsequent changes, new medical contraindications, or on expiration of approved exemption and that any approval is provisional and subject to change based on requirements moving forward.

I verify the information I am submitting to substantiate my request for a medical exemption from the COVID-19 vaccination requirement is true and accurate. I understand any falsified information may lead to disciplinary action, up to and including termination.

I further understand that Centralia School District is not required to provide this exemption accommodation if doing so would create an undue hardship for Centralia School District.

Employee Signature:	Date:

Medical Certification for COVID-19 Vaccine Exemption

Employee Name (print): _____

Centralia School District requires vaccination against COVID-19 as a condition of employment. The individual named above is seeking a medical exemption due to medical contraindications.

Please certify below the medical reason that your patient should not be vaccinated for COVID-19 by completing this form. Information provided on this form will be reviewed in consideration of the exemption request.

1. Does this individual have a disability that necessitates an accommodation?

2. If yes, please list below accommodations that could be made by Centralia School District including but not limited to exemption from the COVID-19 vaccination.

3. Please indicate if the need for the accommodation is permanent or temporary. If temporary, please indicate when the accommodation will no longer be needed.

Certification

I certify that_____(patient name) has the above contraindication and support the request for a medical exemption from the COVID-19 vaccine requirement at Centralia School District.

Provider Information

Medical Provider Name: _____

Medical Provider Specialty: _____

Signature: _____

Provider License Number: _____

Date: _____

Name of Provider Company: _____

Address: _____

Email: _____

Phone number:_____