**FORM D**

**COVID-19 Declination Form 2**

 On August 5, 2021, the Director and State Public Health Officer (the “Director”) for the California Department of Public Health issued *Health Care Worker Vaccine Requirement* (the “Order), which requires vaccination against COVID-19 for health care facility workers. Workers must receive either their first dose of a one-dose regiment or the second dose in a two-dose regiment no later than September 30, 2021.[[1]](#footnote-1)

In order to assess your individual needs and accommodation requests, please complete this form and submit it to **EMPLOYER NAME** to review and determine whether we will be able to accommodate your request.

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

To request an accommodation from the Director’s Order, please complete Section 1 below. If you are requesting an exemption due to qualifying medical reasons you must have your physician, nurse practitioner, or other licensed medical professional practicing under the license of a physician complete Section 2 before returning this form to **EMPLOYER NAME** with a carbon copy to the facility Administrator.

If you are requesting an exemption based on a sincerely held religious belief, we would like to better understand the basis for the exemption and how we can best accommodate your request. Accordingly, we ask that you provide an explanation of the basis for the request for a religion-based exemption by having you or your spiritual leader complete Section 3 below.

**Section 1**

|  |  |
| --- | --- |
| Name (print): | Date: |
| Department:  | Position: |
| Supervisor: | Work/Cell Phone: |

I am requesting an exemption from the Director’s Order for the following reason:

☐ Medical

☐ Religious

I verify that the information I am submitting to substantiate my request for an exemption from the Director’s Order is true and accurate to the best of my knowledge. I understand that any falsified information can lead to disciplinary action, including termination of employment.

I understand that I may not be able to continue to be employed if I do not receive a COVID-19 vaccination within the timeframes established by the Order or otherwise receive an approved exemption due to qualifying medical reasons or a religious accommodation request.

I also understand that if this exemption is granted, I will comply with any and all mandatory non-pharmaceutical interventions that apply or may apply in the future to non-fully vaccinated workers performing my job function.  I understand that, to the extent that any of these mandatory interventions are required of me by the Director’s Order, I will comply with all of them as well as any other applicable public health and safety requirements.  I understand that should I fail to comply with any applicable restrictions, that I may be barred from the premises, or subject to discipline, up to and including immediate termination.

I further understand that **EMPLOYER NAME** is not required to provide this exemption if doing so would pose a direct threat to myself or others in the workplace, if I cannot perform my essential job function without creating an undue burden on my employer or if doing so would violate the Director’s Order.

Employee Signature: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Date: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Section 2**

**Medical Declaration for Vaccination Exemption**

Employee Name: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Dear Medical Provider,

On August 5, 2021, the Director and State Public Health Officer for the California Department of Public Health issued *Health Care Worker Vaccine Requirement*, which requires vaccination against COVID-19 for health care facility workers.

The above-named individual is seeking an exemption from this requirement due to qualifying medical reasons.

Please complete this form to assist **EMPLOYER NAME** in the reasonable accommodation process.[[2]](#footnote-2)

|  |
| --- |
| **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 an exemption from the COVID-19 vaccination for the above-named individual.

**Physician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medical License Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

**Section 3**

**Religious Declaration for Vaccination Exemption**

Employee Name: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Dear Spiritual Leader,

On August 5, 2021, the Director and State Public Health Officer for the California Department of Public Health issued *Health Care Worker Vaccine Requirement*, which requires vaccination against COVID-19 for health care facility workers.

The above-named individual is seeking an exemption from this requirement due to a sincerely held religious belief.

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

|  |
| --- |
| **Please explain the spiritual basis for requesting an exemption from the COVID-19 vaccination:**  |

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

**Religious Leader Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Religious Leader Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Religious Center Name & Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

**FACILITY USE ONLY**

**Employee Name:**

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

Accommodation request:

* Approved \_\_/\_\_/\_\_\_\_

Describe specific accommodation details: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

* Denied \_\_/\_\_/\_\_\_\_

Describe why accommodation is denied: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. Resources regarding the risks and benefits of vaccination against COVID-19 are available at <https://covid19.ca.gov/vaccines/>. [↑](#footnote-ref-1)
2. This form must be signed by a physician, nurse practitioner, or other licensed medical professional practicing under the license of a physician. [↑](#footnote-ref-2)