REQUEST FOR A REASONABLE ACCOMMODATION C19R FORM

REQUEST FOR REASONABLE ACCOMMODATION

For COVID-19 Requirement(s)

Notice to Employees: The information provided below is confidential and will be maintained in a separate confidential file from your personnel file. The information provided will only be used to determine a potential and appropriate accommodation necessary for you, and access will be limited only to those with a need-to-know basis. Submit this Request for a Reasonable Accommodation C19R Form to your Agency/Department Human Resources/Medical Leaves & Accommodation Services contact person.

A. Employee Information:	
Name (Last, First):	Employee ID:
Classification Title:	Work Phone No.:
Agency/Department:	Work Email:
Immediate Supervisor(s)/Manager(s):	

B. Accommodation Information:

Describe the accommodation requested:

Identify duration and frequency of accommodation (if permanent/indefinite, state so) and explain why:

To be eligible for a Qualified Medical Reasons exemption the employee must also provide to their employer a **written statement signed by a physician, nurse practitioner, or other licensed medical professional practicing under the license of a physician** stating that the individual **qualifies for the exemption** (but the statement should not describe the underlying medical condition or disability) and **indicating the probable duration of the worker's inability to receive the vaccine** (or if the duration is unknown or permanent, so indicate).

I have attached a written statement signed by a physician, nurse practitioner, or other licensed medical professional practicing under the license of a physician certifying that I am excused from receiving any COVID-19 vaccine due to a qualifying medical reason (without describing the underlying medical condition or disability) and indicating the probable duration of my inability to receive the vaccine (or that the duration is unknown or permanent).

I will provide a written statement signed by a physician, nurse practitioner, or other licensed medical professional practicing under the license of a physician certifying that I am excused from receiving any COVID-19 vaccine due to a qualifying medical reason (without describing the underlying medical condition or disability) and indicating the probable duration of my inability to receive the vaccine (or that the duration is unknown or permanent) according to the County of Alameda COVID-19 Workforce Vaccination Policy.

C. Employee/Worker Signature and Attestation

By signing below, I affirm and attest that I have provided accurate and truthful responses to each of the statements above. While my request is pending, I understand that I must comply with all other COVID-19 prevention requirements. I understand that the County may need to obtain supporting documentation regarding my medical condition to further evaluate my request for a reasonable accommodation for a medical exemption from the COVID-19 vaccine.

_____ _____

Employee/Worker Signature Date

D. For Agency/Department HR/Medical Leaves & Accommodation Services Use Only:

Approved as requested. Denied

More Information is Needed:

_____

_____

Date Received: _____

Date Discussed with Employee: _____

Date Approved/Denied: _____

Date Employee was Notified: _____

If denied or no agreement on an accommodation, provide an explanation:

D. For Agency/Department HR/Medical Leaves & Accommodation Services Use Only:		
Print Name	Reviewer Signature	Date

cc: Employee
Confidential Medical File