Code No. 403.7E2

MEDICAL ACCOMMODATION REQUEST FORM

Date:	
Employee Name:	
Email Address:	
Position/Job Title:	
Employee Telephone Number:	
Employment Location:	

(1) What is the basis for the medical accommodation that you are requesting?

(2) What are you requesting an accommodation from?

Item	Yes/No
Vaccination for COVID-19	
Testing for COVID-19	
Use of Face Coverings	

_____ _____

Employee Signature Date

Office Use

This request has been:

_____ _____

Approved Denied

_____ _____

Administrator Date

Approved: 1/4/2022