**Accommodation Form**

**Medical Exemption from Covid-19 Vaccination**

Capital Area Community Action Agency requires all employees to secure the Covid-19 vaccination. There are very limited exemptions to this requirement and employees are expected to provide verification of specific needs. This form is to be submitted to human resources by those who are requesting a **medical exemption** to the mandate:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name** |  |  | **Date** |  |
| **Department** |  |  | **Position** |  |
| **Manager** |  |  | **Phone** |  |

Describe the nature of the condition on which your accommodation request is based (please attach medical documentation, if available).

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If medical documentation is not attached, please provide the following information:

|  |  |
| --- | --- |
| Name/Phone/Address of Primary Medical Practitioner/Physician |  |
| Name/Phone/Address of Medical Specialist if applicable |  |

*My signature indicates my permission for* ***Capital Area Community Action Agency*** *to contact my medical practitioner(s) to seek additional clarifying information and for the medical practitioner(s) to release such information as applicable to the evaluation of my request for accommodation. The information provided by me is true and correct to the best of my knowledge.*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | | | | | |
| ***Employee Signature*** | | | | | |
| Date |  | DOB |  | SS# |  |

*Pursuant to section 381.00317(2), Florida Statutes, this completed exemption statement requires the employer to allow the employee to opt-out of the employer’s COVID-19 vaccination mandate.*

***TO BE COMPLETED BY THE EMPLOYEE'S MEDICAL PROVIDER***

|  |  |
| --- | --- |
| **Employee Name** |  |

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|  |  | |
| **Physician, Physician Assistant, or Advanced Practice Registered Nurse**  It is my professional opinion as a physician or physician assistant who holds a valid, active license under chapter 458 or chapter 459, Florida Statutes, or an advanced practice registered nurse who holds a valid, active license under chapter 464, Florida Statutes, that COVID-19 vaccination is not in the best medical interest of the employee. | | |
|  |  |  |
| ***Medical Provider Signature*** |  | ***Date*** |
|  | | |
|  |  |  |
| ***Medical Provider Name (print)*** |  | ***Medical Provider License Number*** |

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| **MEDICAL PROFESSIONAL: Questions? Call 850.222.2043 x 101.**  **Please scan and return this form**   * **via fax to 850.942.2090; or** * **via email to magaret.watson@cacaainc.org.** |

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| ***Management Review*** | | |
|  |  |  |
| **Supervisor** |  | **CEO/COO** |