



Medical exemption

To request an exemption from required vaccinations, please complete section 1 below and have your medical provider complete section 2 before returning this form.

Section 1

Employee name: _____ **Date:** _____

I am requesting a medical exemption from Managed Senior Care. LLC 's vaccination policy for the COVID-19 vaccination.

I verify that the information I am submitting to substantiate my request for exemption from Managed Senior Care. LLC 's vaccination policy is true and accurate to the best of my knowledge. I understand that any falsified information can lead to disciplinary action, up to and including termination.

I further understand that Managed Senior Care. LLC is not required to provide this exemption accommodation if doing so would pose a direct threat to myself or others in the workplace or would create an undue hardship for Managed Senior Care. LLC.

Employee signature: _____ **Date:** _____

Section 2

Medical Certification for Vaccination Exemption

Employee Name: _____

Dear Medical Provider,

[Managed Senior Care. LLC requires vaccination against COVID-19 as a condition of employment. The individual named above is seeking an exemption to this policy due to medical contraindications.

Please complete this form to assist Managed Senior Care. LLC in the reasonable accommodation process.

The person named above should not receive the [insert disease name] 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 exemption from the COVID-19

vaccination for the above-named individual.

Medical Provider Name (print):	
Medical Provide Signature:	Date:
Practice Name & Address:	Provider Phone:

Employer USE ONLY

Date of initial request: __/__/____ Date certification received: __/__/____

Accommodation request:

Approved __/__/____

Describe specific accommodation details:

Denied __/__/____

Describe why accommodation is denied:
