

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