OMB Control No. _____
Est. Avg. Burden per Response: 3 hours

REQUEST FOR A MEDICAL EXCEPTION TO THE COVID-19 VACCINATION REQUIREMENT

Government-wide policy requires all Federal employees, as defined in 5 U.S.C. § 2105, to be vaccinated against COVID-19, with exceptions only as required by law. Employees may seek a legal exception to the vaccination requirement due to a disability, using the form below. The agency may also ask for other information, as needed. Requests for "medical accommodation" or "medical exceptions" will be treated as requests for a disability accommodation and evaluated and decided under applicable Rehabilitation Act standards for reasonable accommodation absent undue hardship to the agency. An employee may also request a delay for complying with the vaccination requirement based on certain medical considerations that may not justify an exception under the Rehabilitation Act. Safer Federal Workforce Task Force guidance on medical considerations that may warrant a delay is available here. The agency will be required to keep confidential any medical information provided, subject to the applicable Rehabilitation Act standards. Employees who receive an exception or a delay from the vaccination requirement would instead comply with alternative health and safety protocols.

Signing this form constitutes a declaration that the information you provide is true and correct to the best of your knowledge and ability. Any intentional misrepresentation to the Federal Government may result in legal consequences, including termination or removal from Federal Service.

To request a medical exception or delay from the COVID-19 vaccination requirement using this form:

1. You must complete Part 1 of this form.
2. Your medical provider must complete Part 2 of this form.
3. When both are completed, you must submit the form to your agency's designated point of contact.

Privacy Act Statement: Pursuant to 5 U.S.C. § 552a(e)(3), the following Privacy Act Statement serves to inform you about personally identifiable and medical information collected through this form. This collection of information is authorized under section 501 of the Rehabilitation Act of 1973, 29 U.S.C. 791; Executive Orders 13164, 13548, and 14043; and 29 C.F.R. pt. 1614. The collected information will be used by the Commission to consider your request for a reasonable accommodation due to a disability under the Rehabilitation Act. Failure to provide this information may result in denial of your request. The information collected in this form may be disclosed in accordance with the routine uses specified in OSHRC-9 (available at https://www.oshrc.gov/privacy), the Commission's system-of-records notice that covers reasonable accommodation records. These records will be retained in accordance with General Records Schedule 2.3, Item 20.

Paperwork Reduction Act Notice: We have estimated that each response to this collection of information by requesters will take 3 hours. Our estimate includes the time necessary to read the instructions, gather the required data, complete Part 1 and review responses, provide the form to medical providers for completion of Part 2, and retrieve the form for submission to the agency. If you have any questions or comments on this estimate, or on how we can improve the collection and reduce the burden it causes you, please contact the Review Commission at (202) 606-5100. You are not required to respond to a collection of information sponsored by the Federal government, and the government may not conduct or sponsor this collection, unless it displays a currently valid OMB control number. This collection has been assigned OMB Control Number _____.

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Part 1 – To Be Completed by the Employee		
Employee Name		**Date of Request**
Department		**Division**
Position	**Supervisor**	**Phone Number**

Medical or Disability Exception Request	
I am requesting a medical exception to the requirement for COVID-19 vaccination or a delay because of a temporary condition or medical circumstance. I declare that the information I have provided is true and correct to the best of my knowledge and ability.	
Employee Signature	
Print Name	**Date**

Part 2 – To be Completed by the Employee's Medical Provider

Employee Name

Medical Certification for COVID-19 Vaccine Exception

Dear Medical Provider:

The Occupational Safety and Health Review Commission requires its employees to be fully vaccinated against COVID-19 pursuant to Executive Order of the President of the United States. The individual named above is seeking a medical exception to the requirement for COVID-19 vaccination or a delay because of a temporary condition or medical circumstance. Please complete this form to assist the Review Commission in its reasonable accommodation process. If you have questions about completing this form, please contact the Review Commission's reasonable accommodation coordinator at dhall@oshrc.gov.

Please provide at least the following information, where applicable:

1. The applicable contraindication or precaution for COVID-19 vaccination, and for each contraindication or precaution, indicate: (a) whether it is recognized by the CDC pursuant to its guidance; and (b) whether it is listed in the package insert or Emergency Use Authorization fact sheet for each of the COVID-19 vaccines authorized or approved for use in the United States;
2. A statement that the individual's condition and medical circumstances relating to the individual are such that COVID-19 vaccination is not considered safe, indicating the specific nature of the medical condition or circumstances that contraindicate immunization with a COVID-19 vaccine or might increase the risk for a serious adverse reaction; and
3. Any other medical condition that would limit the employee from receiving any COVID-19 vaccine.

Description of the medical condition for which the employee listed above should be excepted from complying with a COVID-19 vaccination requirement:

The condition described above is:	☐ temporary	☐ long-term

If this is a temporary condition or medical circumstance, when it is expected to end or expire (allowing for COVID-19 vaccination to begin after the date you provided):

Medical Provider Name/Title

Medical Provider Signature	**Date**