TEMPLATE

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

Authority: The authority to collect the information on Request for a Medical Exception to the COVID-19 Vaccination Requirement Form is 29 U.S.C. 791; 29 C.F.R. Part 1614; 20 C.F.R. Part 1630, Executive Order 13164, and USDA Department Regulation 3800-008, Reasonable Accommodation and Personal Assistance Services for Employees and Applicants with Disabilities.

Purposes: The information on this form may be used by USDA to help determine whether the employee is entitled to an accommodation. Medical information will be treated in a confidential manner and be maintained separately from the employee's official personnel folder in accordance with the requirements of the USDA RA Procedures, Privacy Act and Rehabilitation Act of 1973, as amended. This form will also be utilized to determine the efficacy and consistency of the reasonable accommodation process and be compiled for reports to the Equal Employment Opportunity Commission (EEOC); these records are subject to periodic review by the EEOC, or the Director, Office of Civil Rights, at their request, to ensure compliance.

Routine Uses: This form may be used for Routine Uses set forth in System of Records Notice USDA Personnel Public Health Emergency Records System USDA/OSEC-01. published on Monday, November 8, 2021, Vol 86, Number 213, Page 61747, and USDA/OSEC-02 Contractors and Visitors Public Health and Emergency Records, published on November 9, 2021, Vol 86, Number 214, Page 62142.

Disclosure: Completion of this form is voluntary; however, accommodation may not be given to a qualified individual without this written information. The public reporting burden for this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information.

Part 1 – To Be Completed by the Employee

[Agencies should modify these fields as needed for purposes of identifying 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:

[AGENCY NAME] 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 [AGENCY NAME] in its reasonable accommodation process. If you have questions about completing this form, please contact [AGENCY NAME]'s reasonable accommodation coordinator at [EMAIL AND PHONE HERE].

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**