COUNTY OF LOS ANGELES
MEDICAL/DISABILITY ACCOMMODATION REQUEST FORM
For Exemption From COVID-19 Vaccination Mandate

EMPLOYEE NAME	EMPLOYEE ID
JOB TITLE	LOCATION
DEPARTMENT	SUPERVISOR
PHONE NUMBER	EMAIL

I am requesting, as a reasonable accommodation, an exemption from the County of Los Angeles COVID-19 Vaccination Mandate because I have a medical condition, contraindication, or precaution that prevents me from receiving a COVID-19 vaccine.

I understand that, as part of this request, I must submit a completed ***Healthcare Provider Statement*** from my licensed healthcare provider within ten (10) business days of the date of this request, and that the ***Healthcare Provider Statement*** must be signed by a physician, nurse practitioner, or other licensed medical professional practicing under the license of a physician.

I understand that in the event I cannot submit a completed *Healthcare Provider Statement* within ten (10) business days, I may request an extension in writing from my Departmental HR Manager or their designee.

Please provide any additional information that you think may be helpful in processing your request.

Do <u>not</u> identify your diagnosis, disability, or other protected health information.

EMPLOYEE ACKNOWLEDGEMENT

While my request is pending, I understand that I must comply with the safety practices (e.g., face coverings, regular asymptomatic testing) for unvaccinated or incompletely vaccinated individuals as a condition of my employment. These required safety practices are defined by the Centers for Disease Control and Prevention, the California Department of Public Health, California Department of Industrial Relations, Division of Occupational Safety and Health and Los Angeles County Department of Public Health. I also understand that I must comply with any additional safety practices applicable to my circumstances or position.

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JOB TITLE	DEPARTMENT

If my request is granted, I understand that I will be required to comply with departmental safety protocols for unvaccinated employees as a condition of my employment.

Employee Printed Name	
Employee Signature	
Date	

FOR DEPARTMENT USE ONLY

Date Request Received	
Received By / Title	
Date Receipt of Acknowledgement was sent to Employee	