Felician UNIVERSITY
THE FRANCISCAN UNIVERSITY OF NEW JERSEY

EMPLOYEE INTERACTIVE PROCESS QUESTIONNAIRE

COVID–19 VACCINE EXEMPTION (Medical)
08/06/2021

To: _____

Date Needed: _____

Felician University (Felician) is committed to providing equal employment opportunities without regard to any protected status and a work environment that is free of unlawful harassment, discrimination, and retaliation. As such, Felician is committed to complying with all laws protecting individuals with disabilities or medical conditions. When requested, Felician will provide an exemption/reasonable accommodation for any known medical condition or disability of a qualified individual which prevents the employee from receiving a COVID-19 vaccine, provided the requested accommodation is reasonable and does not create an undue hardship for Felician and/or pose a direct threat to the health or safety of others in the workplace and/or to the requesting employee.

To request an Exemption/Accommodation related to Felician's COVID-19 vaccination policy, please complete **Part 1** of this form, have your healthcare provider complete **Part 2** (the Certification portion), **and return them to Human Resources,** humanresources@felician.edu. This information will be used by Human Resources or other appropriate personnel to engage in an interactive process to determine whether an employee is eligible for such exemption/accommodation and, if so, to determine the reasonable accommodations which can be provided that would enable the employee to perform the essential functions of their position without posing a threat of harm to self or others. If an employee refuses to provide such information, the employee's refusal may impact Felician's ability to adequately understand the employee's request or to effectively engage in the interactive process to identify possible accommodations.

Medical exemptions/accommodations for the COVID-19 vaccine will be considered if the employee provides a written certification by a physician licensed to practice medicine of one of the following:

1. The applicable CDC contraindication for the COVID-19 vaccine; or
2. The applicable contraindication found in the manufacturer's package insert for the COVID-19 vaccine; or
3. A statement that the physical condition of the person or medical circumstances relating to the person is such that immunization is not considered safe, indicating the specific nature and probable duration of the medical condition or circumstances that contraindicate immunization with the COVID-19 vaccine.

Part 1 – To Be Completed by Employee:

Name: _____

Date of Request: _____

Verification and Accuracy

I verify that the information I am submitting in support of my request for an accommodation is complete and accurate to the best of my knowledge, and I understand that any intentional misrepresentation contained in this request may result in disciplinary action. I also understand that my request for an accommodation may not be granted if it is not reasonable, if it poses a direct threat to the health and/or safety of others in the workplace and/or to me, or if it creates an undue hardship on Felician.

Signature:_____

Date: _____

Print Name: _____

Part 2 – To be completed by Employee's Medical Provider:

Employee Name: _____

Attention Medical Provider:

Felician requires a COVID-19 vaccination as a condition of employment. The abovenamed employee is requesting an exemption from this vaccination requirement. A medical exemption from the COVID-19 vaccination may be allowed for certain recognized contraindications.

IMPORTANT NOTE TO HEALTHCARE PROVIDER:

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. **To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information.** "Genetic information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Please complete the form below. Thank you.

The above person should not be immunized for COVID-19 for the following reasons:

_____

_____

_____

Please indicate the specific nature and probable duration of the medical condition or circumstances that contraindicate immunization with the COVID-19 vaccine.

_____

_____

_____

I certify that _____ has the above contraindication and request a medical exemption from the COVID-19 vaccination.

Medical Provider Signature: _____

Date: _____

Print Name: _____

Address:_____

_____

Phone number: _____

AFFIX STAMP BELOW:

Part 3 – To be completed by Human Resources Representative

Date this Request Form Received in Human Resources: _____

Interactive Discussion Date(s) if applicable:

_____

_____

Exemption/Accommodation granted? _____Yes _____ No

Describe Exemption/Accommodation:

_____

_____

If Exemption/Accommodation granted, list required alternative safety precautions required: If Exemption/Accommodation not granted, explain why:

_____

_____

Name of HR Representative: _____

Signature of HR Representative: _____

Date: _____