EMPLOYEE COVID-19 TESTING PROGRAM-

REQUEST FOR MEDICAL ACCOMMODATION OR RELIGIOUS EXEMPTION FROM TESTING

Section 1

Name (print):	Date:
Dept.:	Position:
Manager:	Work/Cell Phone:

I am requesting a☐medical accommodation☐religious exemption ☐other exemption (check applicable box) from Harris County's Employee COVID-19 Testing Program for the following reason(s):

To request a medical accommodation from required COVID-19 Testing, please have your medical provider complete section 2 before returning this form to your department's human resources liaison.

To request a religious exemption from COVID-19 testing, please state above the name of your religion and reasons you are requesting a religious exemption, attach any relevant documentation to support your sincerely-held religious belief, and return to your department's human resources liaison.

To request any other exemption, please provide the reasons you are requesting an exemption above, attach relevant documentation to support your request, and return to your department's human resources liaison.

I verify that the information I am submitting to substantiate my request for an accommodation or exemption is true and accurate to the best of my knowledge. I understand that any falsified information can lead to disciplinary action, up to and including termination.

I further understand that Harris County is not required to provide this accommodation or exemption if doing so would pose a direct threat to myself or others in the workplace or would create an undue hardship for Harris County or the Harris County department that I work for.

Employee Signature:	**Date:**

Section 2

Medical Certification for Accommodation from Harris County's Employee COVID-19 Testing Program

Employee Name: _____

Dear Medical Provider,

Harris County requires employees who are unvaccinated for COVID-19 submit to weekly COVID-19 testing as a condition of employment. The individual named above is seeking an accommodation to this policy due to medical contraindications.

Please complete this form to assist Harris County in the reasonable accommodation process.

The person named above should not be required to submit to weekly COVID-19 testing due to:
This exemption should be: ☐ Temporary, expiring on: __/__/____, or when _____ ☐ Permanent

I certify that the above information to be true and accurate, and request exemption from the weekly COVID-19 testing for the above-named individual.

Medical Provider Name (print):	
Medical Provide Signature:	Date:
Practice Name & Address:	Provider Phone:

HR USE ONLY

Date of initial request: __/__/____ Date certification received: __/__/____

Accommodation or Exemption request:

☐ Approved __/__/____
Describe specific accommodation or exemption details:
_____

☐ Denied __/__/____
Describe why accommodation or exemption is denied:
_____