Medical / Disability Certification for Vaccination Accommodation

Name: _____ Colleague Number (If employee):_____

Relationship with Aultman (circle one below):

Applicant Colleague Non-Employed Physician Volunteer Contractor Student Board Member

Vendor Name (if applicable): _____

Department: _____

Email Address: _____

Dear Medical Provider,

Aultman Health Foundation and its affiliates ("Aultman") requires vaccination against COVID-19 as a condition of employment. The individual named above is seeking an exception to or postponement of vaccination due to medical contraindications and/or because of his/her disability status.

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

The person named above should not receive the following COVID-19 vaccine(s) (check all that apply):

☐ Pfizer-BioNTech ☐ Moderna ☐ Janssen (Johnson & Johnson)

Describe the clinical contraindications for not receiving the COVID-19 vaccine(s):

This accommodation should be:

- ☐ Temporary, expiring on: __/__/____, or when _____
- ☐ Permanent

I certify the above information to be true and accurate.

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

(Note: THIS IS A MEDICAL-LEGAL DOCUMENT; NO STAMP SIGNATURE)