REQUEST FOR MEDICAL ACCOMMODATION RELATED TO COVID-19 VACCINE

To request a medical accommodation from Arkansas Baptist College's requirement for submission of required COVID-19 vaccination documentation, please complete sections 1 and 2. Once completed, students may return this form to the Office of Admissions in person or by email to admissions@arkansasbaptist.edu. Employees may return the form to the Office of Human Resources (via email at hr@arkansasbaptist.edu or deliver in person to the Administration building).

Section 1

Name (print):	Date:
Dept:	Position/Classification:
Supervisor/Advisor:	Work/Cell Number:

I am requesting a medical accommodation related to Arkansas Baptist College's requirement for confirmation of COVID-19 vaccination.

I verify that the information I am submitting to substantiate my request for medical accommodation is true and accurate. I understand that any falsified information can lead to disciplinary action.

I further understand that Arkansas Baptist College is not required to provide this accommodation if doing so would pose a direct threat to others in the living/learning environment or workplace or would create an undue hardship for Arkansas Baptist College.

Section 2 Justification for Medical Exemption/Accommodation

Student/Employee Name: _____

Dear Medical Provider:

Arkansas Baptist College requires confirmation of receipt of COVID-19 vaccination as a condition of on-campus College attendance or employment. The individual named above is seeking an exemption to this policy due to medical contraindications. Please complete this form to assist Arkansas Baptist College in the student accommodation /reasonable accommodation process.

The person named above should not receive the COVID-19 vaccine due to (specify the individual's diagnosis and why the COVID-19 vaccine may be detrimental to the individual's health or is otherwise medically contraindicated for the individual):_____
_____
_____
_____
_____
_____

This exemption should be:
☐ Temporary, expiring on: _____, or when _____
☐ Permanent

I certify that I have a professional provider/patient relationship with the individual named above and that the above information is true and accurate, and I request exemption from the College's requirement to submit confirmation of COVID-19 vaccination for the above-named individual.

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

ADMISSIONS/HUMAN RESOURCES USE ONLY

Date of initial request: _____ Date certification received: _____

Accommodation request:

☐ Approved _____

Describe specific accommodation details: _____
_____

☐ Denied _____

Describe why accommodation is denied: _____
_____

Signature: _____ Date: _____