REQUEST FOR EXEMPTION/ACCOMMODATION DUE TO DISABILITY OR QUALIFYING MEDICAL CONDITION RELATED TO COVID-19 VACCINATION

This form must be completed when applying for an exemption/accommodation from the COVID-19 vaccination requirements due to (1) a qualifying medical condition or (2) a disability as defined by the Americans with Disabilities Act and applicable law. **Portions of this form must be completed and signed by a physician, nurse practitioner, or other medical professional licensed in New Mexico to support the request for accommodation.**

SECTION 1: TO BE COMPLETED BY EMPLOYEE/PARTICIPANT

Name:_____ **Date**: _____

Position:_____

Please select the basis for your accommodation request:

☐ I am seeking an accommodation/exemption from the mandatory COVID-19 vaccination requirement for a **disability**, as defined by the Americans with Disabilities Act and applicable law, that necessitates an accommodation/exemption from the vaccination requirement.

☐ I am seeking an accommodation/exemption from the mandatory COVID-19 vaccination requirement on the basis of a **qualifying medical condition**, which is defined as a permanent or temporary medical condition recognized by the FDA or CDC as a contra-indication to COVID-19 vaccination.

CERTIFICATION OF EMPLOYEE/PARTICIPANT

By signing below, I certify that this statement is true, complete, and accurate to the best of my knowledge. I understand and agree that CGE may need to discuss the nature of my disability/medical condition in connection with the requested accommodation and may request supporting materials to address the request for exemption. I also understand and agree that if my request is granted, I may be required to follow other preventative measures to help slow the transmission of COVID-19 and to protect my own health and that of CGE employees, participants, and others, and I may be subject to testing and other public health requirements to which vaccinated persons may not be subject.

Name (Printed): _____

Signature: _____ Date: _____

SECTION 2: TO BE COMPLETED BY HEALTHCARE PROFESSIONAL

INSTRUCTIONS TO HEALTHCARE PROFESSIONAL COMPLETING THIS FORM: A request for a reasonable accommodation has been made by the employee/participant named above. To assist us with this process, please complete the following questions below as applicable for this employee.

Please do not provide any information beyond what is necessary. Furthermore, please do not provide information relating to any medical condition that does not require accommodation.

Safe Harbor Provision Under GINA. 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 employee or family member of the employee, 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 employee's family medical history, the results of an employee's or family member's genetic tests, the fact that an employee or an employee's family member sought or received genetic services, and genetic information of a fetus carried by an employee or an employee's family member, or an embryo lawfully held by an employee or family member receiving assistive reproductive services.

Provider Name: _____ **Date**:_____

Identify credentials: (M.D. Nurse Practitioner, other): _____
_____

I am a licensed medical professional in the State of New Mexico: Yes No

Contact Information: _____
_____
_____

A. Information to Determine Existence of Disability & Need for Accommodation

PLEASE COMPLETE THIS SECTION **ONLY** IF EMPLOYEE SELECTED ACCOMMODATION REQUEST DUE TO DISABILITY ON PAGE 1

1. Does the individual have a physical or mental impairment? Yes No

2. Does the impairment substantially limit a major life activity? Yes No

   If yes, please explain how the individual's impairment substantially limits any major life activity identified above: _____
   _____
   _____

3. Does the impairment identified about necessitate as an accommodation that the employee be exempt from the mandatory COVID-19 vaccination requirement?
   Yes No
   If yes, please describe: _____
   _____
   _____

4. Identify the expected duration of employee's need for an accommodation:
   _____
   _____
   _____

5. Other Comments/Suggestions

_____

_____

_____

B. Information to Determine Existence of Qualifying Medical Condition

PLEASE COMPLETE THIS SECTION **ONLY** IF EMPLOYEE SELECTED ACCOMMODATION REQUEST DUE TO QUALIFYING MEDICAL CONDITION ON PAGE 1.

1. Does the above-named employee have a permanent or temporary medical condition recognized by the FDA or Centers for Disease Control and Prevention (CDC) as a contra-indication to COVID-19 Vaccination? Yes No

   If yes, please explain: _____

   _____

2. What is the probable duration of the individual's inability to receive a COVID-19 vaccine? _____

   _____

   _____

3. Does the individual qualify for an exemption due to the foregoing qualifying medical condition?

   Yes No

HEALTHCARE PROVIDER SIGNATURE

Print Name of Healthcare Professional:_____

Signature of Healthcare Professional: _____

Date: _____

REQUEST FOR RELIGIOUS EXEMPTION/ACCOMMODATION
RELATED TO COVID-19 VACCINATION

This form must be completed when applying for a **religious exemption** from the COVID-19 vaccination requirements. Its purpose is to assist in establishing the sincerely held religious belief that is the basis for your request and the conflict between your sincerely held religious belief and the COVID-19 vaccination. Philosophical, political, scientific, or sociological objections to the COVID-19 vaccination do not justify an exemption or accommodation. You must demonstrate a sincerely held religious belief which conflicts with the requirement that every employee and participant at CGE be vaccinated against COVID-19.

Name:_____ **Date**: _____

Position:_____

I am requesting an exemption from the mandatory COVID-19 vaccination requirement based on the following religious belief(s) or practice(s): _____
_____
_____
_____

Please explain all reason(s) why you are requesting a religious exemption/accommodation from the COVID-19 Vaccination requirement. Your statement **must** include, but is not limited to, stating the specific reason(s) why you are requesting the religious exemption/accommodation and the specific manner(s) in which the COVID-19 vaccination requirement conflicts with your religious observance, practice, or beliefs. Please include additional pages, if necessary.

_____
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By signing below, I certify that my statement is true, complete, and accurate to the best of my knowledge. I understand and agree that CGE may need to discuss the nature of my religious beliefs/practices in connection with the requested accommodation and may request supporting materials to address the request for exemption. I also understand and agree that if my request is granted, I may be required to follow other preventative measures to help slow the transmission of COVID-19 and to protect my own health and that of CGE employees, participants, and others, and I may be subject to testing and other public health requirements to which vaccinated persons may not be subject.

Employee Name (Printed):_____

Employee Signature: _____ Date: _____