Request for a Medical Accommodation in Connection with COVID-19 Testing

For the purposes of the mandatory weekly Covid-19 Testing Program, this form will be used in lieu of the Request for Disability Related Accommodations and PAI 2.3 Americans with Disabilities Act Amended Act

Employee:

To request a medical accommodation to the COVID-19 testing requirements, please complete, sign and submit this form to the Department of Human Resources. Consideration of a medical accommodation for COVID-19 testing may require interactive discussions with Human Resources and/or medical documentation to support your request.

Employee Name **(first, middle initial., last)**				
Employee Department				
Employee ID Number				
Employee Email Address				
Phone Number				
Provide a brief description of medical condition/disability and requested accommodation:				
Select One:		**Temporary Condition/Disability**		**Permanent Condition/Disability**
If Temporary, Expected Date of Recovery				
NOTE: Extensions will require additional medical documentation				
Medical Practitioner's Name				
Medical Practitioner's Address & Phone Number				

Through submission of this form and my below signature I acknowledge:

- Due to my medical condition, I am unable to participate in COVID-19 testing and I am seeking approval of an exemption through accommodation but, approval is not automatic.
- Whether or not my exemption request is approved, I must comply with safety measures for my own protection and that of other employees and the customers we serve. Such measures include but are not limited to wearing a face mask, social distancing, hand washing, self-monitoring for symptoms or other safety protocols established by the City of Hampton.
- My failure to follow the City of Hampton's safety measures may result in disciplinary action.

This information will be reviewed by Human Resources and maintained in a confidential and secured location. Managers/ supervisors may receive instructions related to the final determination on a need to know basis.

My signature below certifies this is a truthful and accurate request for a medical accommodation to testing for COVID-19.

Employee Signature **(sign in above space)**	**Date (month/date/year)**

For HR Use:

Reviewer Name and Title	
Date received in HR	
Date Documentation Received	
Date(s) of Interactive Discussions	
Final Determination:	
Date and method used to convey determination in writing to Employee such as email receipt, USPS, UPS, etc. and attach to the form.	
Name(s) of Managers/Supervisors Notified:	