CITY OF BOSTON

To request an **accommodation from the COVID-19 vaccination requirement**, please complete Section 1 below and have your medical provider complete Section 2.

Please return this form to accommodation@boston.gov.

Section 1	
Name (print):	Birth Date:
Department:	Employee ID:
Email:	Work/Cell Phone:

I request a medical accommodation from the COVID-19 vaccination verification portion of the City of Boston's Vaccination Verification and/or Regular Testing Policy.

By signing below, I affirm that the information I have provided is accurate and complete to the best of my knowledge and belief, and that any misrepresentation of this information will provide grounds for employment discipline, up to and including termination.

I further affirm my understanding that the City of Boston is not required to provide this accommodation if doing so would pose a direct threat to myself or others in the workplace or would create an undue hardship for the City of Boston.

Employee Signature:	Date of Request:

Section 2

Medical Certification for COVID-19 Vaccination Accommodation

Employee Name: _____

Dear Medical Provider,

The City of Boston requires all of its employees to **EITHER** verify their full vaccination status **OR** engage in regular testing for the COVID-19 virus as a condition of their employment. The individual named above is seeking an accommodation from **the vaccination component of this policy** due to medical contraindications.

Please complete this form to assist the City of Boston in the reasonable accommodation process.

The person named above should not receive the COVID-19 vaccine due to the following medical contraindications:

This vaccination accommodation should be:

☐Temporary, expiring on: __/__/____, or when the following event occurs: _____.

☐Permanent

I certify the above information to be true and accurate and consistent with my legal obligations as a medical practitioner, and request the accommodation(s) stated above for the above-named individual.

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