Grandview Medical

[COMPANY] COVID-19 VACCINATION MEDICAL (INCLUDING PREGNANCY-RELATED) ACCOMMODATION REQUEST FORM (FOR USE OUTSIDE OF CALIFORNIA)

Grandview Nursing & Rehab is committed to providing equal employment opportunities without regard to any protected status and a work environment that is free of unlawful harassment, discrimination, and retaliation. As such, the Company is committed to complying with all laws protecting individuals with disabilities or medical conditions. When requested, the Company will provide a reasonable accommodation for any known medical condition (including pregnancy-related) or disability of a qualified individual which prevents the employee from receiving a COVID-19 vaccine, provided the requested accommodation is reasonable and does not create an undue hardship for the Company and/or pose a direct threat to the health or safety of others and/or to the requesting employee.

To request a reasonable accommodation related to the Company's COVID-19 Vaccination Policy for Employees due to a medical reason (including pregnancy-related), please complete the following steps:

(1) You should complete Part 1 of this form
(2) You should provide this form to your healthcare provider along with a copy of your job description and have them complete Part 2. A copy of your job description can be obtained from your HR Business Partner.
(3) Once your healthcare provider has completed Part 2, return the fully completed form to Human Resources by 11/26/2021.

This information will be used by the Company to engage in an interactive process to determine whether an employee is eligible for such accommodation and if so, to determine the reasonable accommodations which can be provided that would enable the employee to perform the essential functions of their position without posing an undue hardship or a direct threat of harm to the employee or others. If an employee refuses to provide such information, the employee's refusal may impact the Company's ability to adequately understand the employee's request or to effectively engage in the interactive process to identify possible accommodations.

Medical accommodations for the COVID-19 vaccine generally only will be considered if the employee provides written documentation by a licensed, treating medical provider of one of the following:

1. Documented severe or immediate-type allergic reaction to all available COVID-19 vaccines or an ingredient of all available COVID-19 vaccines, **or**
2. A documented medical condition or circumstance relating to the employee such that immunization is not considered safe for the employee, indicating the specific nature and probable duration of the medical condition or circumstances that contraindicate immunization with the COVID-19 vaccine; **or**
3. Other medical or pregnancy-related reason that make immunization contraindicated or unsafe for the employee.

PART 1: TO BE COMPLETED BY EMPLOYEE

Employee Name: _____

Employee ID: _____

Job Title:

I understand that the Company is requiring that U.S. employees comply with its mandatory vaccination policy. I am requesting an accommodation allowing me to remain actively employed by the Company even though I am not fully vaccinated against COVID-19 because of a medical condition (including pregnancy-related) or disability concern. If my

medical condition or underlying need for an accommodation changes and I am able to receive the vaccination in the future, I understand I must notify Human Resources immediately.

I acknowledge that the information that I am submitting in support of my request for an accommodation is complete and accurate to the best of my knowledge. I have read and fully understand the above information on this form.

_____ _____

Employee Signature Date

PART 2: TO BE COMPLETED BY THE HEALTHCARE PROVIDER[1]

The employee's Healthcare Provider should review the following information and respond fully to the questions below:

At this time, the Company requires all of its U.S. employees to receive a COVID-19 vaccination as a condition of employment. Employee has requested an exemption/accommodation due to a medical condition (including pregnancy-related) or disability concern and asks to be permitted to work for the Company even though they are unvaccinated.

We ask that you complete this form so that we can assess the employee's request and determine whether we can reasonably accommodate the employee without posing a significant risk of substantial harm to the health or safety of the employee or others. Please only provide information related to the condition(s) that support or are related to the employee's request for accommodation not to receive the COVID-19 vaccine.

Should you have any questions, please contact Kelli Martz. Thank you.

To assist you in responding to the applicable questions, enclosed is a job description for the employee's position;

Based on my medical opinion, the above person should not be immunized for COVID-19 for the following reasons (check all that apply):

☐ **Documented severe or immediate-type allergic reaction to all available COVID-19 vaccines or an ingredient of all available COVID-19 vaccines.**

If checked, please answer the following questions:

1. List vaccine ingredients to which the employee is allergic:

_____

[1] **A Note to Health Care Providers Assisting Our Employees:**
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 individual or family member of the individual, except as specifically allowed by this law. To comply with this law, you should not gather or provide any genetic information when responding to this request for medical information. "Genetic information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

2. Please provide details regarding the documented severe or immediate-type allergic reaction:

   _____

3. Is there a COVID-19 vaccine currently approved in the United States (including those approved through the Emergency Use Authorization process) that the employee could safely receive?

   Yes___
   No____

   If yes, please indicate which vaccine _____.

4. If the employee's condition that precludes the employee from receiving a COVID-19 vaccine is temporary, state how long the limitation is expected to continue or if it is indefinite:

   _____ Days/Weeks/Months
   _____ Employee's condition is indefinite.

☐ **The employee's medical condition (including pregnancy-related) or medical circumstances are such that immunization with any of the COVID-19 vaccines is not considered safe. Please indicate the specific nature and probably duration of the medical condition or circumstances that contraindicate immunization with any COVID-19 vaccine.**

If checked, please answer the following questions:

1. Does the employee have a physical or mental condition that precludes the employee from receiving one of the COVID-19 vaccines?

   Yes___
   No____

   If yes, please specify the condition:

   _____

2. Is there a COVID-19 vaccine currently approved in the United States (including those approved through the Emergency Use Authorization process) that the employee could safely receive?

   If yes, please indicate which vaccine:

   _____

3. Does the employee's physical or mental condition that precludes the employee from receiving any of the available COVID-19 vaccines substantially limit one or more major life activities? (In this context, "substantially limit" means to make achievement of the major life activity difficult. Whether achievement of the major life activity is "difficult" is an individualized assessment which may consider what most people in the general population can perform with little or no difficulty, what members of the individual's peer group can perform with little or no difficulty, and/or what the individual would be able to perform with little or no difficulty in the absence of disability. Please answer this question without consideration of any mitigating measures.)

   Yes___
   No____

   If yes, please specify the major life activity:

   _____

4. If the employee's condition that precludes the employee from receiving a COVID-19 vaccine is temporary, please state how long the limitation is expected to continue or if it is indefinite:

   _____ Days/Weeks/Months
   _____ Employee's condition is indefinite.

☐**Other medical or pregnancy-related reason. Please provide detailed information in a separate narrative that describes your medical opinion why an exemption/accommodation from the Company's mandatory vaccination policy.**

1. Does the employee have a physical or mental condition that precludes the employee from receiving one of the COVID-19 vaccines?
   Yes___
   No____

If yes, please specify the condition: _____

2. Is there a COVID-19 vaccine currently approved in the United States (including those approved through the Emergency Use Authorization process) that the employee could safely receive? If yes, please indicate which vaccine _____.

3. Does the employee's physical or mental condition that precludes the employee from receiving any of the available COVID-19 vaccines substantially limit one or more major life activities? (In this context, "substantially limit" means to make achievement of the major life activity difficult. Whether achievement of the major life activity is "difficult" is an individualized assessment which may consider what most people in the general population can perform with little or no difficulty, what members of the individual's peer group can perform with little or no difficulty, and/or what the individual would be able to perform with little or no

difficulty in the absence of disability. Please answer this question without consideration of any mitigating measures.)

Yes___
No____

If yes, please specify the major life activity: _____

4. If the employee's condition that precludes the employee from receiving a COVID-19 vaccine is temporary, state how long the limitation is expected to continue:

_____ Days/Weeks/Months
_____ Employee's condition is indefinite.

_____ _____
Healthcare Provider's Signature **Date**

_____ _____
Area of Practice/Specialty **Phone Number**

Grandview Religious

COVID-19 Religious Accommodation Request Form

Policy Statement & Instructions:

Consistent with federal, state and local law, the Company provides reasonable accommodation for individual's sincerely held religious beliefs, practices, and observances unless providing a reasonable accommodation would result in undue hardship to the business. If you are seeking an accommodation from the COVID-19 vaccination program due to religious reasons, please complete this form and return it to Kelli Martz.

We request you complete this form because, in some cases, a person's religious beliefs may be more subjective than objective. If your religious accommodation is not required by the tenets of a specific religion, the Company will need to understand the basis and source of your religious beliefs to reasonably assess whether your request qualifies for a religious accommodation. This is the reason for many of the questions below. The information you provide will allow us to evaluate your request and decide whether we can grant an accommodation in this instance. It is possible that more information will be necessary to evaluate your request, and if so, we will follow up with you for more information or documentation. We will inform you once a decision is made on your request.

Company Expectations for Cooperation and Honesty:

As COVID-19 continues to significantly challenge our employees, customers and business, it is more important than ever to work cooperatively with one another. The Company respects employee religious and personal beliefs but also expects employees to cooperate as the Company evaluates accommodation requests, including but not limited to providing true and accurate information in furtherance of accommodation requests. If the Company determines employees have failed to cooperate with its reasonable information requests or employees have acted dishonestly in advancing such requests, it may deny the accommodation request and, if appropriate, take disciplinary action including potentially terminating an employee's employment.

Employee Name: _____

Position: _____

Department: _____

1. Please describe in detail the provision(s) of the Company's COVID-19 vaccination program from which you are seeking accommodation and the accommodation you are requesting.

_____

_____

_____

2. Please identify the religious belief, practice, or observance that is causing you to seek the accommodation identified in response to Question No. 1.

_____

3. Please describe the conflict between such religious belief, practice, or observance and the provision(s) of the COVID-19 vaccination program identified in response to Question No. 1.

4. Is the religious belief, practice, or observance you identified in response to Question No. 2 based on an organized religious faith to which you belong, and if so, please describe?

5. If your request for accommodation is not based on an organized religious faith to which you belong, please describe the basis for the religious belief, practice, or observance you have identified in response to Question No. 2.

6. If your request is related to receiving the COVID-19 vaccine, please answer the following questions:
    a. Have you received other vaccinations previously? If so, please describe why the religious belief, practice, or observance you have identified did not prevent you from getting that vaccination(s).

b. Would receiving a COVID-19 vaccine interfere with your ability to practice your religion? If so, please explain.

7. Please describe how the religious belief, practice, or observance you have identified in response to Question No. 2 effects other aspects of your life, such as if it prevents you from receiving certain medical care.

8. Please describe any workplace changes you are seeking if you do not participate fully in the COVID-19 vaccine program, other than the accommodation request identified in response to Question No. 1.

9. Is there anything else you would like the company to know about your request for accommodation? If so, please provide that information here or attach any documents you wish to provide.

Employee Acknowledgment: I acknowledge that I have read and understand this request form and that all statements made above are complete and accurate to the best of my knowledge. I understand that any intentional misrepresentation contained in this request may result in disciplinary action. I understand that the accommodation requested above may not be granted if I have not identified a religious belief,

practice, or observance that conflicts with the COVID-19 vaccination program or if the accommodation is not reasonable or imposes an undue hardship.

Date: _____ Signature: _____

Name: _____