HEADQUARTERS
2293 Tripaldi Way, Hayward, CA 94545
Phone 510.293.1993

REQUEST FOR EXEMPTION/ACCOMMODATION: MEDICAL EXEMPTION FROM COVID-19 VACCINATION

California Hydronics Corporation, Inc. (the "Company") 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 part of this commitment, the Company complies with all laws protecting individuals with disabilities or medical conditions. When requested, the Company will provide a vaccine exemption and a reasonable accommodation for any known medical condition 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 in the workplace and/or to the requesting employee.

To request an Exemption/Accommodation related to the Company's COVID-19 vaccination policy, please complete **Section 1** of this form, have your healthcare provider complete **Section 2** (the certification portion), and return to Donna Kronenberg by enter date. Also sign the separate Authorization for Release of Medical Information form and return it to Donna Kronenberg at the same time. This information will be used by HR or other appropriate personnel to engage in an interactive process to determine eligibility for and to identify possible accommodations. 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, and the request may be denied.

Accommodation requests are confidential, and the Company will not retaliate in any way against an employee for making a request.

To Be Completed by Employee:

Name (print):	Date:
Dept.:	Position:
Manager:	Work/Cell Phone:

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I have been advised by a health care professional that I should not receive the COVID-19 vaccination: ☐ Yes ☐ No

Employee Verification and Accuracy

I verify that the information I am submitting is true and accurate to the best of my knowledge. I understand that any intentional misrepresentation may lead to disciplinary action, up to and including termination.

To be eligible for this exemption, I further understand that I must also provide to my employer a medical certification signed by a physician, nurse practitioner, or other qualified licensed medical professional, stating that I qualify for the exemption (but the written statement should not describe the underlying medical condition or disability) and indicating the probable duration of my inability to receive the vaccine (or if the duration is unknown or permanent, so indicate).

I also understand that my request for an accommodation may not be granted if it is not reasonable, if it poses a direct threat to the health and/or safety of others in the workplace and/or to me, or if it creates an undue hardship on the Company.

Employee Signature _____ Date _____

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To be completed by Employee's Medical Provider

Medical Certification for Vaccination Exemption

Employee Name: _____

Attention Medical Provider:

The Company requires a COVID-19 vaccination as a condition of employment. The above-named employee is requesting an exemption/reasonable accommodation from this vaccination requirement. A medical exemption from the COVID-19 vaccination may be allowed for certain recognized contraindications.

Please complete this form to assist the Company in the reasonable accommodation process. Should you have any questions, please contact _____ at _____. Thank you.

By completing and signing this form, I certify that my patient listed above should not receive the COVID-19 vaccine due to (*explain the specific contraindication to vaccination here, but do **not** identify the underlying medical condition or disability*):
This exemption should be: ☐ Temporary, expiring on: __/__/____, or when _____ ☐ Permanent

I certify the above information to be true and accurate, and request exemption from the COVID-19 vaccination for the above-named patient.

Medical Provider Name (print):	
Medical Provider Signature:	Date:

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Practice Name & Address:	Provider Phone: