COVID-19 Vaccination Exemption – Medical Accommodation Request Form

PART 1: Employee to complete if a medical provider has instructed employee not to vaccinate against COVID-19 due to a medical condition. Once the medical provider has completed Part 2, please upload this fully completed form to Mployee Central or scan and email to benefit@masonite.com.

Employee Name: ____ Employee Number: ____________________

Employee Job Title: ______________________________________ Employee Work Location: ______________

Employee Email: ____ Employee Phone Number: ______________

Company Expectations for Employee Cooperation and Honesty

As COVID-19 continues to significantly challenge our employees, customers, and business segments, it is more important than ever to work cooperatively with one another. The Company respects employee medical restrictions 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 exemption 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 exemption accommodation request and, if appropriate, take disciplinary action, up to and including termination.

Before submitting this form to Masonite, I acknowledge that I have read and understand this request form and that all statements made in this form are complete and accurate to the best of my knowledge. I understand that any misrepresentation contained in this request may result in disciplinary action, up to and including termination.

I also understand that if I am granted an exemption accommodation, I will need to comply with alternate safety requirements which often include face covering and weekly testing. I further understand that, if approved, an exemption accommodation may impact the availability of work for me to perform and/or that an exemption accommodation may include placement on an unpaid leave.

Date ____

Employee Signature ____

Employee Name: ______________________________________ Employee Number: ___________________

Employee Job Title: ____________________________________ Employee Work Location: ______________

Employee Email: ______________________________________ Employee Phone Number: ______________

PART 2: Medical Questionnaire to be completed by the medical provider.

This inquiry was prompted by the disclosure by our above-named employee that a medical impairment(s) prevents the employee from becoming fully vaccinated against COVID-19 (Fully vaccination for these purposes means receiving both doses of a two-dose vaccine or the sole dose of a one dose vaccine.)

Please answer, fully and completely, any applicable question(s) below. Please do not respond unless the employee authorizes you to do so. If the employee works or resides in California, do not disclose and diagnoses without the employee's specific consent. Once you have completed this form, please provide it to the employee to submit to Masonite.

NOTE: The Genetic Information Nondiscrimination Act of 2008 (GINA) and similar state laws generally prohibit employers and other entities covered by GINA Title II (and similar state laws) from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by law. To comply with applicable law(s), we are asking that you not provide and genetic information or results of genetic tests, as defined by applicable law(s), when responding to this request for medical information. By way of example, "genetic information" (as defined by federal law) 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.

1. Does the employee have a medical impairment(s) that results in an inability to be fully vaccinated against COVID-19?

   ☐ YES ☐ NO

   If you answered "No," do not answer the remaining questions, but complete and sign the "Certification" at the end of this document.

   If you answered "Yes," is/are the impairment(s) ________ temporary or _______ permanent?

   If temporary, when will the impairment(s) end, or when do you reasonably predict it/they will end?

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2. Please describe in detail how the employee's medical impairment(s) renders the employee unable to be fully vaccinated against COVID-19?

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3. Please list the other vaccinations (other than COVID-19) the employee would have received, but for the medical impairment, but has not received due to the employee's medical condition(s) and how do those vaccinations differ from the COVID-19 vaccination?

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4. Please list the vaccinations the employee has received and how do those vaccinations differ from the COVID-19 vaccination?

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5. Are there accommodations that will reduce or eliminate the threat of injury/harm posed to the employee's own health and/or safety – or the health/safety of other in the workplace – while the employee is at work given that the employee is not fully vaccinated against COVID-19?

   ☐ YES ☐ NO

6. If you answered "Yes," please describe all such accommodations in detail and explain how these accommodations will reduce or eliminate the threat:

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CERTIFICATION

By signing below, I certify that the answers provided in response to the above questions are based on my own personal knowledge of the relevant medical facts from my own examination of the patient/employee or based on my own review of the relevant medical documentation, and my answers represent my professional medical opinion.

Health Care Provider's Name (please print)	
Health Care Provider's Signature	
Date	
Provider's Specialty or Type of Practice	
Provider's Telephone Number	
Provider's Office Address	