RCUH
Research Corporation
of the University of Hawai‘i
Human Resources Department

RCUH Medical Accommodation Request Form
Medical Exemption from COVID-19 Vaccination

Return to RCUH Human Resources via email: rcuhhrdirector@rcuh.com.

Requests are considered pending until a Determination letter has been issued by the Director of Human Resources.

The Research Corporation of the University of Hawai`i (RCUH) Mandatory Vaccination Policy demonstrates our commitment to protecting the health and safety of our employees and community at large. RCUH is also committed to complying with all applicable laws protecting employees with disabilities and/or medical conditions. The RCUH will review an employee's request for a Medical Accommodation for any known medical condition or disability that prevents the employee from receiving a COVID-19 vaccine, provided the requested accommodation is reasonable and does not create an undue hardship for the organization or pose a threat to the health or safety of others in the workplace. To request an accommodation for an exemption from COVID-19 vaccination, please complete Section A of this form and have a medical provider complete Section B. Upon completion, please return this form along with any supporting documentation to RCUH Director of Human Resources via email: rcuhhrdirector@rcuh.com. RCUH will use this information to provide the employee with guidance and to facilitate an interactive process (as necessary) in the accommodation assessment process.

SECTION A: Employee Information and Certification

1. Contact Information:

Employee Name:	**RCUH ID:**
Phone:	**Email Address:**

STATUS (check box): ☐ Current Employee ☐ Rehire or New Hire (Pending final approval to start work)

2. **Certification:** I hereby verify that the information I am submitting in support of my request for an exemption is accurate, and I understand that any falsification or misrepresentation may result in disciplinary action, including possible termination of employment. (If electronic signature is used, attach the electronic signature audit page if applicable.)

____________________________________ ____________

Employee Signature Date

SECTION B: Medical Provider Information and Certification

1. Medical Provider Contact Information

Medical Provider's Name:
Address of Medical Provider:
Phone Number:

2. Explain why the person named in Section A should not receive a COVID-19 Vaccine:

3. This exemption should be:

☐ Temporary – Expiration Date: ________________

☐ Permanent

4. **Certification:** I certify that this information is accurate and that the employee named in Section A has the above contraindication. I request a medical exemption from the COVID-19 vaccine requirement for the employee. (If electronic signature is used attach the electronic signature audit page if applicable.)

____________________________________ ____________

Medical Provider Signature Date

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