|  |  |
| --- | --- |
|  | **City of Madison - APM 2-53 Attachment A**  **COVID-19 Reasonable Accommodation-Medical** |

**Employee Name**       

**Employee Number**       **Department**      

**Supervisor/Manager**       **Job Title**       

It is the policy of the City of Madison to provide reasonable accommodations to qualified individuals with disabilities in accordance with the federal Americans with Disabilities Act (ADA) and other related legislation affecting individuals with disabilities. You will be required to provide documentation in support of your request for a reasonable accommodation.

**EMPLOYEE CERTIFICATION**

I have a disability or medical condition that prevents me from receiving any COVID-19 vaccine or adhering to COVID-19 testing practices. NOTE: To be eligible for this exemption, I understand that I must also provide Human Resources a written medical certification signed by a physician, nurse practitioner, or other licensed medical professional practicing under the license of a physician, stating that I qualify for the exemption (but the written medical certification should **not** identify the underlying medical condition or disability).

I have received and reviewed information on the City of Madison’s COVID-19 Vaccination/Testing Policy. I understand that a detailed review of my disability status may be required, and I agree to cooperate fully in this process. I further understand that if my request is approved, I am obligated to report any changes in my disability status, which may require a re-evaluation of this request. Granting this request does not signify approval of any future reasonable accommodation request for any other position within this department or any other department within the City of Madison.

I hereby certify that I make this request based on my belief that I have a disability or medical condition that prevents me from complying with COVID-19 vaccination and testing requirements. I understand that any falsified information can lead to disciplinary action, up to and including termination of employment.

I further understand that the City of Madison is not required to provide this exemption accommodation if doing so would pose a direct threat to myself or others in the workplace or would create an undue hardship.

**Employee Signature Date**

Please note that this information will be maintained in a separate confidential file from your personnel file and access will be limited only to those with a need-to-know.

**FOR HR USE ONLY DATE RECEIVED: \_\_/\_\_/20\_\_ MEDICAL CERTIFICATION RECEIVED \_\_ YES \_\_ NO**

**DATE MEDICAL CERTIFICATION RECEIVED: \_\_/\_\_/20\_\_**