DENSO
Crafting the Core

Disability/Medical Request for Accommodation Form: COVID-19

To request an accommodation from the Company COVID-19 vaccination policy and/or Healthy Horizons Wellness Premium Incentive, please complete this form and upload to the Qualtrics COVID-19 Records System.

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

Part 1: Associate / Spouse

I am requesting a medical accommodation as to the Company policy regarding COVID-19 vaccination and/or Healthy Horizons Wellness Premium Incentive ("Accommodation") I understand that upon submitting this request, I may be asked by the Company to provide additional information in support of my Accommodation request, including information from my healthcare provider. I understand that if granted this Accommodation from the Company, I may be required by applicable law and/or Company policy to submit to weekly testing and other mitigation measures.

The reason for the requested Accommodation is: ____

____

Despite the exemption I seek above, I believe the following Accommodation would be effective at: (1) allowing me to perform all essential functions of my position, and (2) keeping both myself and all others in the workforce safe from the spread of COVID-19:

____

Under the American with Disabilities Act (ADA), when an individual qualifies for reasonable accommodation, the employer is free to choose among effective accommodations, and may choose one that is less expensive or easier to provide. Also, please understand that Company is not required to provide an accommodation if doing so would pose a direct threat to you or others in the workplace or would create an undue hardship for the Company. By signing below you are authorizing the Company to request and obtain medical information and records from your healthcare provider to the extent appropriate and necessary to support your request.

The information provided by me is true and correct to the best of my knowledge. I understand that providing false or misleading information may be grounds for discipline, up to and including termination of employment. I authorize the Company to explore coverage and reasonable accommodations under the ADA, including requesting medical records and protected health information from my healthcare provider to process this request. I understand that all information obtained during this process will be maintained and used in accordance with ADA and any other applicable confidentiality requirements.

Signature:	Date:

Part 2: Medical Certification for Exemption

Associate/Spouse Name: ____

Company Name: DENSO

Dear Medical Provider,

The individual named above is seeking an exemption from a DENSO policy on the basis that they are entitled to a medical accommodation from receiving the COVID-19 vaccine.

Please complete the below form to assist DENSO evaluating this exemption request.

The person named is entitled to a medical accommodation and should be exempted from receiving the COVID-19 vaccine due to:
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 above mentioned policy/requirement for the above-named individual.

Medical Provider Name (print):	
Medical Provider Signature:	Date:
Practice Name & Address:	Provider Phone:

HR USE ONLY

Date of initial request: __/__/____ Date certification received: __/__/____

Accommodation request:

☐ Approved __/__/____

Describe specific accommodation details:

____

☐ Denied __/__/____

Describe why accommodation is denied:

____