Medical Accommodation Request Form

This form and a copy of your physician's/nurse practitioner's Medical Contraindication for COVID-19 Vaccination letter must be completed and submitted to Human Resources.

Employee's full name: ____

Department: ____

By signing below I confirm that:

- I have a medical condition that requires accommodation from the *COVID-19 Mandatory Vaccine Protocol for High-Risk Settings,*
- the attached Medical Contraindication for COVID-19 Vaccination letter is accurate and was completed by my physician/nurse practitioner,
- I consent to my employer contacting my physician/nurse practitioner to confirm my qualification for an accommodation,
- I understand that my employer reserves the right to impose additional restrictions or requirements on me for health and safety reasons which may not apply to fully vaccinated employees, and
- I understand that I can face disciplinary measures (including dismissal) for submitting a false or fraudulent accommodation request.

I understand that the information collected herein is for the purpose of safeguarding the health and wellbeing of the workplace, and is collected in accordance with the Nova Scotia *Health Protection Act* and the *COVID-19 Mandatory Vaccination Protocol for High-Risk Settings*.

By signing below, I hereby consent to the collection, use, and disclosure of this information for the purposes of administering the *COVID-19 Mandatory Vaccination Protocol for High-Risk Settings*, and I recognize that it will be accessed, used, and disclosed only in accordance with that policy and/or as required or permitted by law.

Print Name: ________________________________ Signature: _________________________________

Date [DD/MM/YYYY]: _______________________