Request for COVID-19 Policy Accommodation

Please complete, sign and email this form (including the attached health care provider certification, if applicable, as explained below) to AccommodationReview@92Y.org, so that we may determine whether you qualify for a reasonable accommodation.

NAME OF PERSON REQUESTING ACCOMMODATION: _____

ADDRESS: _____

TELEPHONE: _____ EMAIL: _____

PERSON COMPLETING THIS APPLICATION: _____

(If different from person requesting accommodation, indicate relationship): _____

Please indicate the basis for your request:

□ **Medical**

□ **Religious**

□ **Other**

Please provide additional information about the reason for your request for accommodation (including as applicable a description of your medical condition or religious belief that precludes you from following one or more COVID-19 policies):

DO NOT PROVIDE INFORMATION ABOUT GENETIC TESTS, GENETIC SERVICES, OR ANY FAMILY MEDICAL HISTORY.

_____

_____

_____

If the reason is medical, we will require you to have the attached certification completed by your health care provider, confirming that you are under their care, and that they are recommending that you receive accommodation as a result of your medical condition/need. Once we have received your response, we will contact you to assess the appropriate accommodation, if any, under the circumstances. Any request that we grant is conditional and subject to reconsideration based on business needs and Company policy, which we reserve the right to change at any time.

If you have any questions, please contact AccommodationReview@92y.org.

Signature:

Name: _____ Date_____ *(mm/dd/yyyy)*

CERTIFICATION OF HEALTH CARE PROVIDER

COVID-19 POLICY ACCOMMODATION

Individual's name:_____
First Middle Last

HEALTH CARE PROVIDER

Your patient has requested an accommodation in the form of an exception to one or more of our COVID-19 policies. Please provide your contact information, complete the information below, and sign the form. Limit your response to the medical condition(s) for which the individual is seeking an exception to our COVID-19 policy. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the individual's family members, 29 C.F.R. § 1635.3(b).

Health Care Provider's name: *(Print)* _____

Health Care Provider's business address:_____

Type of practice / Medical specialty: _____

Telephone: (_____) Fax: (_____) E-mail:_____

By signing below, I hereby certify that all of the following is true and correct:

- The individual listed above is currently my patient and under my professional medical care.
- Due to a disability/medical condition, I am recommending that my patient receive a reasonable accommodation to the following COVID-19 policy:_____

The medical condition(s) supporting the above recommendations is/are: _____

_____

Signature of Health Care Provider _____ **Date**_____ *(mm/dd/yyyy)*