University HOSPITAL
Newark, NJ

ACCOMMODATION REQUEST/CONSENT FORM AND ATTESTATION

Please complete this form to request an accommodation based on religion or because of a disability. If you are requesting an accommodation due to a disability you must provide medical or other appropriate documentation.

Requests for an accommodation regarding the Influenza vaccine for **RELIGIOUS REASONS** should be submitted to myloa@uhnj.org

The information provided to the Human Resources Department will be maintained in confidence and shared only to the extent necessary to facilitate your accommodation request.

Name:	**A#:**
Home Address: **City/State/Zip Code:**	**Job Title:**
Department:	**Date of Hire:**
Home Telephone:	**Work/Mobile Telephone:**
Your email:	**Supervisor (first and last name):**

Type of Accommodation: DISABILITY ☐ **Learning** ☐ **Physical** ☐ **Pregnancy** ☐ **Psychological** ☐ **RELIGIOUS** ☐

A. Questions to clarify accommodation requested.

If you are not sure what accommodation is needed, do you have any suggestions about what options we can explore? ☐ Yes ☐ No

If *yes,* please explain.

Is your accommodation request time sensitive? □ Yes □ No

If *yes*, please explain.

B. Questions to document the reason for accommodation request.

What, if any, job function are you having difficulty performing?

What, if any, employment benefit are you having difficulty accessing?

What limitation is interfering with your ability to perform your job or access an employment benefit?

Have you had any accommodations in the past for this same limitation? □ Yes □ No

If *yes*, what were they and how effective were they?

If you are requesting a specific accommodation, how will that accommodation assist you?

Please provide a description, in your own words, of the specific ways in which a COVID-19 Vaccine or the Influenza Vaccine conflicts with your religious beliefs. If there is other information supporting your exemption application, which you would like to be considered, please submit that information with your description.

C. Other

Please provide any additional information that might be useful in processing your accommodation request.

PHYSICIAN CONTACT INFORMATION (Employees only) (Please provide the name, address, telephone and fax numbers). The physician may receive a letter/fax from us requesting information on your impairment/disability and recommendations for accommodations.

□ I hereby give my consent to my medical provider(s) to speak with Sherronda Williams or her designee in the Department of Human Resources, about my medical condition and its effect on my employment at University Hospital.

□ I authorize the release of necessary confidential medical information regarding my disability to relevant personnel as deemed necessary by Human Resources. I also attest to the fact that a copy of the job description has been given to me for review and reference.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting, or requiring, genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

□ I hereby attest that I am required to wear a mask while at University Hospital's owned or leased property. If I do not wear a mask, I will be denied access to University Hospital's owned or leased property and may be subject to discipline up to and including termination.

Requestor's Signature:_____ **Date:**_____

***Human Resources ONLY**: Granted □ Yes □ No-Reason*_____ *Date:*_____

All Pages Must Be Completed