



2017 Request for Religious Exemption – Influenza Vaccine

Applications must be submitted no later than Wednesday, November 1, 2017. You will be notified if your exemption application has been approved or not. If you do not have an active email account, you will be contacted at the phone number you provide below.

Submit your completed form to **personnel@uabmw.org** or **FAX to (205) 481-7700**. In order for your application for exemption to be considered, all information requested must be provided, and all questions must be answered. **Please note, all information will be kept confidential.**

Should your exemption application be approved, Medical West Administration may institute additional controls if the prevalence of influenza within the community rises to a concerning level, including having you wear a surgical mask or procedure mask and/or reassignment of work schedules and duties.

Employee Section – complete the following information (print)

Name (last, first): _____

Department: _____ **Job Title:** _____

Best Contact Phone Number : _____

Email Address: _____

Do you understand that you will be asked to submit an application for religious exemption annually (having been approved for an exemption one year does not automatically mean your exemption will be approved another year)? Yes No

In some cases, Medical West will need to obtain additional information and/or documentation about religious practice(s) or belief(s) as part of an interactive process with the requesting employee to assess the need and qualification for an exemption. We may need to discuss the nature of your religious belief(s), practice(s), and accommodation with you or your religion's spiritual leader (if applicable) or religious scholars to address your request for an exception. It is expected that all employees cooperate with Medical West in any interactive dialogue that is needed to assess the need and qualification for an exemption, and failure to cooperate in the process could result in denial of the exemption request.

If requested, can you provide documentation to support your belief(s) and need for exemption? Yes No

If no, please explain why: _____

Do you provide direct patient care? Yes No

Do you work in an area where patient care is provided (e.g. unit or clinic)? Yes No

Do you have contact with patients/visitors (e.g. registering, providing directions, taking payments)? Yes No

Do you provide services to patients/visitors (e.g. food preparation, financial counseling, music therapy)? Yes No

Please explain why you are seeking an exemption (attach additional sheets if necessary):

I verify that the above information is complete and accurate to the best of my knowledge, and I understand that any untrue or intentional misrepresentation contained in this request may result in disciplinary action, up to and including termination of my employment. **I also understand that my request for an exemption may not be granted if it is not reasonable or if it creates an undue hardship on my employer.**

Signature: _____ Date: _____

Print Name: _____

OFFICE USE ONLY

Request is: Approved Denied

Signature: _____ Date: _____

Print Name: _____

Comments:
