SMART ENERGY DECISIONS

SED Event attendee request for medical accommodation

As the COVID-19 pandemic continues to pose a direct threat to the health and safety of our employees, their families, event attendees, and the community at large, SED is committed to providing and maintaining event environments that are free of known hazards. To this end, we are requiring all SED event attendees to be vaccinated against COVID-19. Although in the vast majority of cases an individual's health condition makes vaccination against COVID-19 desirable, SED recognizes that in individual circumstances, a medical condition or disability may prevent someone from getting vaccinated, as determined by their healthcare provider.

To request a medical accommodation, up to and including an exemption, from the requirement to provide proof of your COVID-19 vaccine, please complete Section 1 below and have your health care provider complete Section 2.

Materials relating to an attendee's medical accommodation request, including this written request for accommodation and any other documentation information, will be kept confidential, but may be disclosed for business reasons or as necessary to effectuate the accommodation.

Part 1 - To Be Completed By Attendee

Name:
Company:
Phone Number:
Email:
Date of Request:
What Event is the Accommodation Sought For:
Dates of Event:

I am requesting medical accommodation from the SED policy requiring event attendees to have received the COVID-19 Vaccine. I verify that the information I am submitting to substantiate my request for an accommodation is true and accurate to the best of my knowledge.

_____ _____

Attendee Signature Date

Part 2: Medical Certification for Vaccination Accommodation
Patient Name:

Dear Healthcare Provider,

Smart Energy Decisions (SED) requires all event attendees to have received the COVID-19 vaccine. The individual named above is seeking an accommodation or exemption to this policy due to medical contraindications.

Please complete this form to assist SED in the reasonable accommodation process, attaching additional pages if needed.

1. **Does the patient have a physical or mental condition that prevents them from being able to receive a COVID-19 vaccination?**

YES
NO

If the answer to Question 1 is "No," then skip the remainder of this form and complete the signature and information section at the end.

2. **If the answer to Question 1 is "YES," please provide a description of the physical or mental conditions that affect the patient's ability to receive the COVID-19 vaccination. NOTE: Do NOT disclose the diagnosis or specific condition of the patient.**

3. **What are the medical facts that indicate your patient should not receive a COVID-19 vaccine? NOTE: Do NOT disclose the diagnosis or specific condition of the patient.**

4. **Does your patient need any other modification or other accommodation in response to the information indicated in response to Question 1?**

YES
NO

5. **If the answer to Question 4 is "YES," please describe in detail the suggested modification(s) or other accommodation(s).**

CERTIFICATION OF PHYSICIAN/HEALTH CARE PROVIDER
I hereby certify that all of the foregoing information is true and correct.

_____ _____
Signature of Provider Printed Name of Provider

Licenses and Specialties of Provider:
Date Signed:
Address of Provider:
Telephone Number of Provider:

Part 3 - To Be Completed by SED
Date of Request:
Date of Interactive Discussion(s):
Did documentation come with the request?
Yes
No

Is more documentation necessary?
Yes
No

Reasonable accommodation:
Approved
Denied

Nature of accommodation provided (if any):
If accommodation denied, please explain why:
Dates reasonable accommodation effective:
Additional comments (if any):
SED Signature:
SED Name:
Date: