

GENERAL DYNAMICS

Electric Boat

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Name (print)		Badge #	Date
<input type="text"/>	<input type="text"/>	<input type="text"/>	
Department #	Work/Cell Phone	Home Phone	

REQUEST FOR MEDICAL EXEMPTION FROM COVID-19 VACCINATION MANDATE

The federal government recently released COVID-19 Workplace Safety Guidance, which includes a COVID-19 vaccination mandate for all employees of covered federal contractors. Employees who are seeking a medical exemption from the vaccination mandate, once it is invoked on Electric Boat ("EB"), should complete this form.

To request a medical exemption from the COVID-19 vaccination requirement, please complete Part 1 of this form, have your medical provider complete Part 2, and return the completed form to: COVIDVaccinationMedicalExemptionRequests@gdeb.com. This information will be used by Medical, Human Resources or other appropriate personnel to engage in an interactive process to determine whether you are eligible for such exemption and if so, to determine reasonable accommodations which can be provided that would enable you to perform the essential functions of your position. If you refuse to provide such information, your refusal may impact EB's ability to adequately understand your request or to effectively engage in the interactive process to identify possible accommodations.

Incomplete forms will be returned to you. Note that you may be placed on an unpaid leave of absence pending a decision about your medical exemption request.

Section 1: To be completed by Employee:

I am requesting an exemption from the federal mandate requiring that covered federal contractors be fully vaccinated against COVID-19 due to my medical condition. I verify that the information I am submitting to substantiate my request for an exemption based on my medical condition is true and accurate to the best of my knowledge. I further understand that EB is not required to approve this exemption request if doing so would pose a direct threat to the health or safety of myself or others in the workplace or would create an undue hardship for EB. I understand that EB may need to obtain supporting documentation to further evaluate my request for a medical exemption. I understand that if I submit an incomplete form, it may be returned to me.

By completing this form, I grant EB permission to collect information to support my request for a medical exemption.

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Name (print)

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Please indicate your contraindication(s) to the COVID-19 vaccination:

- Severe allergic reaction (e.g. anaphylaxis) after previous dose or to a component of the vaccine
- Immediate allergic reaction of any severity after a previous dose or known (diagnosed) allergy to a component of the vaccine
- History of myocarditis or pericarditis unrelated to or after a first dose of an mRNA COVID-19 vaccine*
- Monoclonal Antibody Treatment (MABS) within the 90 days prior to October 1, 2021 (healthcare worker should get vaccinated no later than 91 to 120 days after MABS)

- Physical condition or medical circumstances that are contraindicated. Please indicate the specific nature and probable duration of the circumstance or medical condition:

Probable duration: _____

1. Identify any accommodations that you feel may be effective at allowing you to remain unvaccinated against COVID-19, while still allowing you to perform all essential functions of your job. Please be as specific as possible:

2. If the above accommodation cannot be granted, describe any alternative accommodations you feel would be equally effective at allowing you to remain unvaccinated against COVID-19, while at the same time allowing you to perform all essential functions of your job:

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3. Identify the time period for which the accommodation is requested. If the accommodation is only needed occasionally, describe the time period, frequency, or circumstances as specifically as possible:

Additional comments:

The information in this request is true and accurate. I understand that any intentional misrepresentation contained in this request may result in disciplinary action up to and including termination of employment. I authorize EB to request and obtain additional information if necessary to support my request.

Employee Signature:	Date:
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Section 2: To be completed by Medical Provider

Dear Medical Provider,

As you know, the federal government recently released COVID-19 Workplace Safety Guidance, which includes a COVID-19 vaccination mandate for all employees of covered federal contractors. The below named employee is seeking an exemption to this COVID-19 related safety requirement due to his/her medical condition(s).

Employee Name (print)

Department #

Badge #

Please indicate the above-named employee's contraindication(s) to the COVID-19 vaccination:

- Severe allergic reaction (e.g. anaphylaxis) after previous dose or to a component of the vaccine
- Immediate allergic reaction of any severity after a previous dose or known (diagnosed) allergy to a component of the vaccine
- History of myocarditis or pericarditis unrelated to or after a first dose of an mRNA COVID-19 vaccine*
- Monoclonal Antibody Treatment (MABS) within the 90 days prior to October 1, 2021 (healthcare worker should get vaccinated no later than 91 to 120 days after MABS)
- Physical condition or medical circumstances that are contraindicated. Please indicate the specific nature and probable duration of the circumstance or medical condition:

Probable duration: _____

* People with a history of myocarditis or pericarditis unrelated to mRNA COVID-19 vaccination may receive COVID-19 vaccination after the episode of myocarditis or pericarditis has resolved. See "Considerations for vaccination of people with certain underlying medical conditions" in *CDC Interim Clinical Considerations for Use of COVID-19 Vaccines Currently Authorized in the United States* for more information: <https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html#underlying-conditions>

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Name (print)

Badge #

Date

1. Please print your name, specialty, address, and telephone number:

Name (print)

Phone Number

Date

Specialty (print)

Address line 1 (print)

Address line 2 (print)

Town (print)

State

Zip Code

2. When is the last time you treated this employee?

3. For what condition did you last treat this employee?

4. For what condition are you requesting a medical exemption from the COVID-19 vaccination for this employee?

5. What medical evidence supports your request for the medical exemption on behalf of this employee? Please provide all citations.

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6. Does your national licensing board or association, state medical board, or licensing agency approve of a medical exemption from the COVID-19 vaccination?

7. If your national licensing board or association, state medical board, or licensing agency does not approve of a medical exemption from the COVID-19 vaccination, please explain the basis for this exemption request.

I authorize EB to contact me directly for additional information and/or clarification about my knowledge of the above-named individual's medical condition(s) and objection(s) to the COVID-19 vaccination requirement.

Name (print)

Signature

Date

Phone Number