MANDAN, HIDATSA, ARIKARA NATION
HUMAN RESOURCE DEPARTMENT
Three Affiliated Tribes ~ Fort Berthold Reservation
404 Frontage Road New Town, ND 58763
Phone: 701-627-4781 Fax 701-627-2960

Request for Medical Exemption from COVID-19 Vaccination

To request an exemption from the required vaccination, please complete section 1 below and have your medical provider complete section 2 before returning this form to the Human Resources Department.

Section 1 *(To be completed by the employee)*

Name (print):	Date:
Dept.:	Position:
Manager:	Work/Cell Phone:

I am requesting a medical exemption from the Three Affiliated Tribes' (or "TAT") mandatory vaccination policy for the COVID-19 vaccination.

I verify that the information I am submitting to substantiate my request for exemption from the TAT vaccination policy is true and accurate to the best of my knowledge. I understand that any falsified information can lead to disciplinary action, up to and including termination. I voluntarily agree that my medical provider as indicated below may provide this information to TAT and its Human Resources Department (or "HR"), and that TAT and HR may receive it.

I further understand that TAT is not required to provide this exemption accommodation if doing so would pose a direct threat to myself or others in the workplace or would create an undue hardship for the TAT.

Employee Signature:	Date:

Section 2 *(To be completed by the medical provider)*
Medical Certification for Vaccination Exemption

Dear Medical Provider,
TAT requires vaccination against the *COVID-19* as a condition of employment. The individual named above is seeking an exemption to this policy due to medical contraindications. Please complete this form to assist the TAT in the reasonable accommodation process.

The person named above should not receive the COVID-19 vaccine due to valid medical contraindications.

This exemption should be:

- ☐ Temporary, expiring on: __/__/____, or when _____
  _____
- ☐ Permanent

I certify the above information to be true and accurate, and request exemption from the COVID-19 vaccination for the above-named individual.

Medical Provider Name (print):	
Medical Provide Signature:	Date:
Practice Name & Address:	Provider Phone:

HR USE ONLY
Exemption request:

- ☐ Approved __/__/____
- ☐ Denied __/__/____
  Describe why accommodation is denied:_____
  _____

Human Resources Director:_____

Human Resource Department
Received Stamp