

# Face Covering Exemption Medical Certification Form

Employer name: \_\_\_\_\_ E-mail: \_\_\_\_\_

Employer address: \_\_\_\_\_ Telephone: \_\_\_\_\_

## Employee to complete the following:

I, \_\_\_\_\_, hereby declare under penalty of perjury, that the information below is complete and accurate. I certify that I meet one or both of the requirements for face covering exemption as outlined below:

1. The employee has a physical, mental, or medical health condition, or disability that prevents wearing a face covering over the nose and mouth. This includes persons with a medical condition for whom wearing a face covering could obstruct breathing in that it would exacerbate the existing condition and put the employee at greater risk.
2. The employee is hearing impaired, or communicating with a person that is hearing impaired, where the ability to see the mouth is essential for communication.

Employee name: \_\_\_\_\_ Date: \_\_\_\_\_

Employee signature: \_\_\_\_\_

## Health Care Provider to complete the following:

I certify that the above employee is a patient under my care and meets one or more of the conditions outlined above. The employee is unable to wear a:

Face covering: \_\_\_\_\_ face shield with drape: \_\_\_\_\_ or both: \_\_\_\_\_ (Initial on applicable line)

Probable duration of need for accommodation: \_\_\_\_\_

**Health Care Provider Signature:** \_\_\_\_\_

**Health Care Provider Printed Name:** \_\_\_\_\_

**Health Care Provider Specialty:** \_\_\_\_\_

**Health Care Provider Address:** \_\_\_\_\_

**Health Care Provider Phone:** \_\_\_\_\_

**Date signed:** \_\_\_\_\_

Place stamp here:

If your health care provider determines that you are medically unable to wear a face covering or face shield, the Practice will engage with you in the interactive process to determine whether and what accommodations (e.g. reassignment, leave of absence, etc.) may be available that can be implemented without undue burden on the practice operations or presenting imminent threat to the health and safety of you, or others, in the workplace.