Request for Religious Accommodation Related to Flu Vaccine

Howard County General Hospital is committed to diversity and inclusiveness of all our employees. To consider your request for a religious workplace accommodation, please provide the following information:

Part 1 – To Be Completed by Employee (additional sheets may be used, if necessary)

Name: ____ **Date of Request:**___________________________

Department: ______________________ **Manager:** ____

Reason for Request:

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Suggested reasonable accommodation to meet your requirements or limitations:

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If you have requested this religious accommodation before, please state approximately when the prior request was made, the name of the individual who responded and the outcome of the request:

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Religion Tenet(s) Documentation

In some cases, HCGH will need to obtain documentation or other authority regarding your religious practice or belief. We may need to discuss the nature of your religious belief(s), practice(s) and accommodation with your religion's spiritual leader (if applicable) or religious scholars to address your request for an accommodation.

If requested, can you obtain documentation or other authority to support the need for an accommodation based on your religious practice or belief?

Yes __________ No __________

Verification and Accuracy

I verify that the above information is complete and accurate to the best of my knowledge and I understand that any intentional misrepresentation contained in this request may result in disciplinary action.

I also understand that my request for an accommodation may not be granted if it is not reasonable or if it creates an undue hardship on my employer.

Signature: ____ Date: ________________

Print Name: ____

Summary of Next Steps

1. **This request will be completed by the employee requesting a religious accommodation.**
2. **You will submit your request to the Sr. Vice President, Human Resources no later than November 1st.**
3. **You will be notified of the decision and/or the proposed accommodation within thirty (30) days.**
4. **If you disagree with the decision or proposed accommodation, please contact the Department of Human Resources, Howard County General Hospital for assistance at 410-740-7851.**

Part 2 – To be completed by HR Representative

Interactive Discussion Date:

____

Employee's Suggested Accommodation: ____

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Results of Interactive Discussion: ____

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Evaluation of Impact (if any): ____

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Accepted: ______ **Not Accepted:** ______

If Not Accepted, Why? :

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Alternative Accommodations (list in order of preference):

1. ____

2. ____

3. ____

Effective Date of Accommodation: ____________________________

Duration Period of Accommodation: __________________________

Document reason denying request for a reasonable accommodation: ________________________

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Department Head's Signature: ______________________________________**Date:** ______________

HR Representative: ____**Date:** _______________

cc: Employee
Employee's Manager/Director
Department of Human Resources, Howard County General Hospital