ATLANTA PUBLIC SCHOOLS

Office of Employee Relations
130 Trinity Avenue SW
Atlanta, Georgia 30303

Request for Medical Exemption from COVID-19 Surveillance Testing

Atlanta Public Schools (APS) requires that all faculty and staff comply with COVID-19 surveillance testing twice per week and other preventive requirements, such as wearing a mask. A medical exemption may be granted if (1) a licensed physician completes and signs this form and (2) provides the required documentation to support the exemption request, and (3) engages in the interactive process. APS is committed to providing a safe, inclusive, and supportive experience for ALL employees and recognizes sincere observance as it pertains to the practice of testing.

While APS will carefully review all requests for medical exemptions, approval is not guaranteed. After your request has been reviewed and processed, you will be notified if an exemption has been granted or denied. If approved and the exemption contains an expiration, you will be expected to complete the requirement at that time. Decisions are final and not subject to appeal. Individuals whose requests have been denied are permitted to reapply if new documentation and information should become available.

Name:_____
Last **First** **MI**

Phone:_____ **Email Address:** _____

Mailing Address:_____
Street **City** **State** **Zip Code**

School/Department:_____

Employee ID#:_____ **Job Title:** _____

Medical exemption process:

- Read the surveillance testing program description at COVID-19 Surveillance Testing;
- Complete and sign page two (2) of this form;
- Have your Licensed Health Care Provider complete the provider section of this form; and
- Submit the completed documents.

Incomplete submissions will not be reviewed. Be sure all forms and documentation are submitted at one time.

Please check all that apply:

☐	I request exemption from the COVID-19 surveillance testing requirement due to my current **medical condition**. I understand and assume the risks of non-vaccination. I accept full responsibility for my health, thus removing liability from Atlanta Public Schools (see page 3).
☐	I request exemption from the COVID-19 **vaccination to be eligible for the paid leave incentive** due to my current **medical condition**. I understand and assume the risks of non-vaccination. I accept full responsibility for my health, thus removing liability from Atlanta Public Schools (see page 4).

Please initial below:

	I understand that I may be temporarily excluded or reassigned from APS facilities and approved activities, if needed during the processing of this request. I agree to comply with these restrictions and accept responsibility for communicating with my supervisor and/or Office of Employee Relations/Absence Management as appropriate to allow compliance with health and safety requirements for unvaccinated individuals.
	Should I contract COVID-19, I will immediately report it to my supervisor and complete this self-report form for data tracking purposes: http://tinyAPS.com/?CovidStaffForm. I will not report to work in person until I have completed the required quarantine procedures based on Public Health guidance.
	I acknowledge that I have read the COVID-19 Surveillance Testing.
	I understand and agree to comply with and abide by all APS COVID-19 policies and procedures.
	I understand that, if approved, this exemption is provisionally based on the current APS COVID-19 testing procedures and is subject to change based on the requirements moving forward.
	I certify that the information I have provided in connection with this request is accurate and complete as of the date of submission. I understand this exemption may be revoked and I may be subject to APS disciplinary action if any of the information I provided in support of this exemption is false.

Printed Name: _____

Signature: _____ Date: _____

Health Care Provider Use Only: Please see COVID-19 Surveillance Testing

APS policy requires that all faculty and staff participate in COVID-19 surveillance testing twice per week._____(Insert patient's name) is requesting a medical exemption from this **testing requirement.** The test that will be administered is the BinaxNow Rapid Antigen Test by Abbott. Here is the EUA from the FDA with details of the test, its use, and applicability. The method we will be using is an anterior nasal swab.

A medical exemption may be allowed for certain recognized contraindications. Please certify below the medical reason that your patient should not be tested for COVID-19 by completing this form and attaching available supporting documentation. Information provided on this form will be reviewed in consideration of the exemption request.

Please certify below the medical reason that your patient should not be screened weekly for COVID-19 by completing this form and attaching available supporting documentation.

- ☐ **Allergy**
- ☐ **Physical Condition/Medical Circumstance**
- ☐ **Other**

Please Explain:

_____

_____

_____

_____

_____

_____

_____

This exemption should be:

- ☐ Temporary, expiring on:_____.
- ☐ Permanent

Certification

I certify that_____(patient's name) has the above contraindication and support the request for a medical exemption from the COVID-19 testing requirement.

Health Care Provider Use Only:

_____(Insert patient's name) is requesting a medical exemption from receiving the COVID-19 **vaccination.**

TO BE ELIGIBLE FOR THE PAID LEAVE INCENTIVE

A medical exemption may be allowed for certain recognized contraindications. Please certify below the medical reason that your patient should not be vaccinated for COVID-19 by completing this form and attaching available supporting documentation. Information provided on this form will be reviewed in consideration of the exemption request.

Please certify below the medical reason that your patient should not be vaccinated for COVID-19 by completing this form and attaching available supporting documentation.

☐ **Allergy**
☐ **Physical Condition/Medical Circumstance**
☐ **Other**

Please Explain:

_____

_____

_____

_____

_____

_____

_____

This exemption should be:

☐ Temporary, expiring on:_____.
☐ Permanent

Certification

I certify that_____(patient's name) has the above contraindication and support the request for a medical exemption from the COVID-19 vaccination.

Provider Information

Medical Provider Name: _____

Medical Provider Specialty: _____

Signature: _____

Provider License Number:_____ Date: _____

Name of Provider Company: _____

Address: _____

Email:_____ Phone number: _____

Patient Information

Patient Name: _____

Date:_____Employee ID: _____

Work Email: _____

Phone number: _____

Please return the completed Employee Accommodation Request Form to the Office of Employee Relations**, ATTN: TONI SELLERS-PITTS/ABSENCE MANAGEMENT**, using one of the following methods.

Hand Delivery: Atlanta Public Schools, **Attn: Office of Employee Relations –Toni Sellers-Pitts**, 130 Trinity Avenue, SW, Atlanta, Georgia 30303 **Fax**: (404) 802-1302
Mail: Atlanta Public Schools, **Attn: Office of Employee Relations –Toni Sellers-Pitts**, 130 Trinity Avenue, SW, Atlanta, Georgia 30303, **Email**: Covid19Exempt@atlanta.k12.ga.us