COVID-19 Vaccine Accommodation Request Form

In an effort to maintain the health and safety of our workforce, KSI Auto Parts (the "Company") has adopted a policy requiring that its employees receive the COVID-19 vaccine. However, in accordance with its commitment to equal employment opportunities, the Company will provide reasonable accommodations with respect to this policy to qualified individuals with a disability, and to employees due to pregnancy, childbirth, breastfeeding, or related medical conditions, to the extent required by applicable federal, state, and/or local law, in order for the employee to perform the essential functions of their position, so long as such accommodation does not impose an undue hardship on the Company. If you would like to request a reasonable accommodation with respect to the Company's COVID-19 vaccination requirement for any of the foregoing reasons, please:

- Submit this COVID-19 Vaccine Accommodation Request Form and the attached Authorization for Release of Information.
- Ask your physician or health care provider to complete Section II of this COVID-19 Vaccine Accommodation Request Form and return it as directed below. Prior to giving the form to your physician or health care provider, please complete Section I below and include the attached copy of your job description. All documents, including the job description, must be attached to this form.
- Submit the completed forms to Human Resources at hr@ksiautoparts.com.

The contents of this request are confidential and will only be shared as needed with the appropriate personnel to consider the implementation of any accommodation. Once Human Resources has received your completed forms, they will contact you to discuss the next steps of this process.

100 Wade Avenue
South Plainfield NJ 07080
908.754.7154
www.ksiautoparts.com

COVID-19 Vaccine Accommodation Request Form

Section I

To be completed by employee

Employee Full Name | Print

Job Title

Supervisors Name

Department

Is the accommodation you are seeking due to a disability, pregnancy, childbirth, breastfeeding, or medical condition related to pregnancy or childbirth? ____ Yes ____ No

If No, please identify the basis for your accommodation request.

How Long will you need the requested accommodation?

Release of Information

I hereby authorize the release of the information in Section II of this Form to KSI for the purpose of determining the availability of workplace accommodations. Because I am seeking an accommodation in the form of an exemption from the Company's COVID-19 vaccination requirement due to a medical condition or disability, I further authorize KSI to seek clarification of this documentation if necessary by contacting my physician.

Employee Signature ____________________ Date ____________

Section II

To be completed by the Physician or Medical Care Provider.

To Physician or Medical Care Provider:

In an effort to maintain the health and safety of our workforce, KSI Auto Parts is requiring its employees to receive the COVID-19 vaccine. Your patient has informed us that they have a medical condition or disability and needs an accommodation, potentially in the form of an exemption from the Company's COVID-19 vaccination requirement. As the employee's physician or health care provider, you are asked to fully complete Section II of this Form. To assist you with completing this form, enclosed is a copy of the employee's job description. If the job description has not been provided or you require additional information to complete this form, please contact the employee and let them know you cannot complete this form without those materials. Thank you for your assistance.

Employee / Patient Full Name | Print ____________________

Health Care Provider Full Name | Print ____________________

License Number ____________________ ____ Medical or Osteopathic Physician ____ Nurse Practitioner ____ Physician's Assistant

Address ____________________ Phone ____________ Fax ____________

I hereby certify that the above-referenced patient qualifies for a medical exemption from the 2021 - 2023 SARS-CoV-2 (COVID-19), vaccine as further provided below:

Reason for Exemption ____ CDC Contraindication ____ CDC Precaution ____ Manufacturer's Insert Contraindication

This contraindication or precaution is ____ Permanent ____ Temporary

If temporary, the expiration date for the exemption is ____________

Health Care Provider's Signature ____________________ Date ____________