**[AGENCY]**

**EMPLOYEE ATTESTATION AND**

**REQUEST FOR EXTENSION OF TIME FOR**

**EXEMPTION FROM COVID-19 VACCINE REQUIREMENT**

**Please return this form to [AGENCY] Human Resources at: [\_\_\_\_\_\_\_\_\_\_\_\_@state.nm.us]**

*To Be Completed by Employee Pursuing Exemption:*

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Supervisor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, by signing below, attest to the following:**

* **I understand that the August 17, 2021 Public Health Order (on Vaccination) (“PHO”) requires me to receive a COVID-19 vaccination requirement for continued employment in my current position with [AGENCY].**
* **I understand that the PHO requires me to receive the first dose of a COVID-19 vaccine no later than August 27, 2021.**
* **I am pursuing a medical condition-related or disability-related exemption from the COVID-19 vaccine requirement.**
* **I have made the following attempts, but have been unable, to obtain a statement from a licensed medical professional explaining and supporting my need for an exemption from the COVID-19 vaccine requirement:**

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Licensed Medical Professional  | Date of Attempted Contact  | Method of Contact | Result of Attempted Contact |
| *Ex.: Dr. Garcia* | *8/19/21* | *Phone – 505.000.1234* | *First Available Appointment 8/30/21* |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

* **I understand that while I am not fully vaccinated, I must be tested for COVID-19 every week, as required by Executive Order 2021-046, and must comply with the masking requirements of any operative public health order.**
* **I verify that these statements and the information I am submitting are truthful and accurate to the best of my knowledge, and I understand that any misrepresentation or falsehood contained in my attestation may result in disciplinary action, up to and including dismissal.**

**Based on my Attestation above, I am requesting additional time to obtain a statement from a licensed medical professional explaining and supporting my need for an exemption from the COVID-19 vaccine requirement of the PHO.**

**Print Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*To Be Completed by [AGENCY]:*

Employee Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Supervisor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Extension of Time to Submit Exemption Request:**

**□ Approved**

**You are granted a [*#*]-day extension of time. Accordingly, you have until [*date*] to submit a statement from a licensed medical professional explaining and supporting your need for an exemption from the COVID-19 vaccine requirement or to obtain your first COVID-19 vaccine.**

**□ Denied**

**Your request for an extension of time is denied. You have already been granted [*#*] additional days to obtain a statement from a licensed medical professional. No further extensions will be granted. Pursuant to the PHO, you are required to obtain your first COVID-19 vaccine no later than [*date*].**

**[*AGENCY HEAD*] signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Supervisor signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*To Be Completed by Employee:*

By signing below, I certify that I understand and will comply with the terms of the approval or denial received above, as applicable, and all COVID-19-related [*AGENCY*] policies and procedures.

**Employee signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_