DEPARTMENT CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) COVID-19 VACCINATION RELIGIOUS EXEMPTION

DEPARTMENT OF HUMAN SERVICES
HUMAN RESOURCES
SFN 1473 (2-2022)

The North Dakota Department of Human Services (Department) recognizes the importance of creating a safe environment, free of infection/transmission of disease and to protect our clients, employees, students, volunteers, visitors, and community from exposure to COVID-19. COVID-19 vaccination is required for all employees that more than likely will enter a Centers for Medicare and Medicaid Services (CMS) facility and have contract with clients/residents of that facility. Individuals who maintain a sincerely held religious belief, practice, or observance requiring abstention from receiving the COVID-19 vaccination may be exempted from receiving vaccination. Religious exemptions must be re-assessed/reapproved each year. Therefore, an updated form must be completed on an annual basis. Religious exemption approvals and accommodations may be reconsidered by the Department at any time.

Date of Request	Requestor Name	Best Phone Number to Reach You

REASON FOR ACCOMMODATION REQUEST

(Briefly identify and describe the nature of your sincerely held religious belief, practice, or observance, explain why an accommodation is required, and what is the accommodation that you are requesting).

ALTERNATIVE ACCOMMODATION

(List any alternative accommodation that also would eliminate the conflict between the vaccination requirement and your sincerely held religious belief, practice, or observance).

My religious beliefs and/or practices, which result in this request for a religious accommodation, are sincerely held. I understand that the accommodation requested may not be granted. Even if the request is granted, the Department will attempt to provide a reasonable accommodation, but one may not be possible without causing an undue hardship on the Department, its employees, and its clients. If approved, I will be required to comply with the CMS facility's requirement for not Fully Vaccinated individuals. I may also be responsible for all costs to comply with the CMS facility's requirements for not Fully Vaccinated individuals.

Signature	Date

TO BE COMPLETED BY THE DEPARTMENT AUTHORIZED REVIEWER

Date Request Received

Evaluation to Request

☐ Approved (if approved, describe the accommodation provided and why (also explain why the suggested alternative accommodation was not accepted):

☐ Denied (If unable to accommodate, provide an explanation below):

DEPARTMENT REVIEWER

Printed Name	
Signature	Date