

**Request for MEDICAL ACCOMMODATION regarding
mandatory vaccination for visiting Village Manor restaurants (Madison Avenue Pub, Paupers Pub)**

To protect the health and safety of participants in its activities, Village Manor is requiring all guests to be fully vaccinated against COVID-19 as a condition of visiting its restaurants.

Any affected person who is unable to be vaccinated for substantiated medical reasons and/or on grounds protected under the Ontario *Human Rights Code* may request an accommodation. By submitting this form, you acknowledge that you are seeking a medical accommodation to Village Manor's COVID-19 vaccination requirement.

Complete SECTION 1 of this Form and have your Physician / Nurse Practitioner complete SECTION 2.

Completed forms are to be emailed to: info@pauperspub.com 48 hours prior to visit.

PLEASE READ CAREFULLY:

- Requests for accommodation will be considered upon completion and presentation of this form.
- Individuals with an approved accommodation will be notified in writing using the email address provided by them in the form below
- Decisions will be made in accordance with Village Manor's Vaccination Policy. In the event a request is denied, individuals are permitted to reapply if new documentation and/or information becomes available.
- This form only applies to requests for medical accommodation from Village Manor's COVID-19 vaccination requirement. If you are seeking accommodations for other purposes, you will be required to make a separate application in accordance with existing procedures. If you have a previously-approved accommodation, you must still submit this form if you wish to be considered for a COVID-19 vaccination accommodation.

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SECTION 1 – TO BE COMPLETED BY GUEST

| (A) GUEST'S INFORMATION | |
|---|-------------------|
| Last Name: | First Name: |
| Email address: | Tel: |
| <p>By submitting this form, I am requesting that I be exempted from Village Manor's COVID-19 vaccination requirement based on a medical condition and affirm as follows:</p> <ol style="list-style-type: none">1. I understand that Village Manor may approve accommodation measures that require me to follow additional health and safety protocols, including, but not limited to:<ol style="list-style-type: none">a. wearing a valid face mask during entire visit, including while sitting at table, with the exception of when eating and drinkingb. remain seated at all time except when visiting washroom and payingc. complete contact tracing and active health screening2. I understand that should an outbreak occur, the Ontario government and/or the applicable public health authorities may impose additional restrictions or requirements on me for health and safety reasons, which may not apply to fully vaccinated participants.3. I understand that Village Manor may have the information in this completed form reviewed by applicable medical specialists.4. I understand that as part of the accommodation process Village Manor may seek additional information. | |
| <hr/> Signature of individual (or parent/legal guardian for those under 18 years of age) | <hr/> Date |

SECTION 2 – TO BE COMPLETED BY PHYSICIAN OR NURSE PRACTITIONER

Declaration of Physician or Registered Nurse in the Extended Class (Nurse Practitioner)

I certify that, based on my examination and/or my knowledge of the medical history of the above-named person, receipt of any COVID-19 vaccine approved by Health Canada is medically contra-indicated and they should be exempted from the requirement for those visiting Village Manor restaurants to be fully vaccinated against COVID-19. I have completed an individual assessment, considered the [Ministry of Health: COVID-19 Vaccination Recommendations for Special Populations](#) and/or the [Canada Public Health Recommendations on the Use of COVID-19 Vaccinations](#) and reviewed risks and benefits with the above-named person.

*Please describe how receipt of any COVID-19 vaccine approved by Health Canada is medically contra-indicated for your patient. **It is not necessary to provide a diagnosis.***

If the medical condition is temporary, please indicate the expected time period for the medical condition:

From: _____ to _____.

Name of Physician or Nurse Practitioner:

Registration/License No.:

Business address and contact information:

Signature of Physician or Nurse Practitioner

Date