Updated October 21, 2021

<u>Aloha Harvest COVID-19 Workplace Protocols</u>

Safety in Practice:

1. Masks are strictly enforced at work—especially indoors, public areas, and while interacting with our partners.
2. Hands are washed often and hand sanitizer is utilized when sink not available.
3. Work surfaces are wiped down throughout the day.
4. Social distancing of at least 6 ft. from others is maintained at all times or when practically possible.
5. Temperature checks are performed at beginning of each shift. Some individuals who are infected with COVID-19 do not always have a fever (100.4°F or higher), so employees are instructed to not report to work if they have any flu-like symptoms.

Following a Flexible "Vaccine or Test" Policy:

<u>Purpose</u>

In accordance with Aloha Harvest's duty to provide and maintain a workplace that is free of known hazards, we are adopting this policy to safeguard the health of our employees and their families; our customers and visitors; and the community at large from infectious diseases, such as COVID-19 or influenza, that may be reduced by vaccinations. This policy will comply with all applicable laws and is based on guidance from the Centers for Disease Control and Prevention and local health authorities, as applicable.

<u>Scope</u>

Effective November 1, 2021, all Aloha Harvest employees are required to be either fully vaccinated against COVID-19 or submit a negative COVID-19 test result weekly.

Employees hired after November 1, 2021 are required to be fully vaccinated by their first day of work or submit a negative test result dated no more than three days prior to their first day of work, with subsequent weekly testing as described below.

Employees working from home/remotely who have no contact in the course of their job duties with co-workers, customers or the public are not covered by this policy.

Aloha Harvest collects and retains a confidential tracker of vaccinated employees' verified vaccine information including secured photocopy of vaccine card. Employees, regardless of vaccination status, are required to comply with any restrictions that third parties have implemented.

Reasonable Accommodation

Employees in need of an exemption from this policy due to a medical reason, or because of a sincerely held religious belief, must submit a completed request for accommodation form to the Executive Director to begin the interactive accommodation process as soon as possible. Fill out the attached request form and submit to the Executive Director. Accommodations will be granted where they do not cause Aloha Harvest undue hardship or pose a direct threat to the health and safety of others.

COVID Testing:

- There are no current requirements as it pertains to the type (i.e. PCR, rapid, etc.) of weekly or close contact testing.
- Aloha Harvest suggests to seek free statewide community testing that can be found at https://preventcovidhi.com/ or the use of at-home testing kits.
- Aloha Harvest is required to pay employees for the time spent for COVID testing if they must test during normal working hours.
- Any time away from the workplace or off-duty hours used for testing and/or quarantine will require employee to utilize company's current Sick Day allowance (7 days per calendar year) OR option of PTO or unpaid leave.
- In case the time away from work exceeds the available Sick and PTO days, the option to exercise Temporary Disability Insurance (TDI) may be applicable.

If Employee Tests Positive for COVID-19:

Aloha Harvest is responsible for asking the employee to identify coworkers and clients/vendors they have come into close contact with. The Executive Director will initiate the contact tracing process by communicating to the potentially exposed employees and/or third parties.

Employee will follow home isolation guidance listed in chart below for "*Positive COVID-19 test (Unvaccinated and Fully Vaccinated)*"

As a reminder, a negative test is not required in order to return to work on the 11th day after date of last exposure (as long as no symptoms persist and 24 hours have passed since using fever-reducing medications).

It is suggested to wait 24 hours before cleaning and disinfecting the worksite to minimize potential for other employees being exposed to respiratory droplets. If waiting 24 hours is not feasible, will wait as long as possible or make other arrangements for work to continue.

(Guidance provided by ProService Hawaii and Hawaii State Department of Health)

Management of Employees Experiencing Symptoms and Direct or Potential Exposure:

Aloha Harvest will follow the guidelines that the Hawaii State Department of Health has outlined:

Situation	Testing/Isolation/Quarantine	Outcome
COVID-19-like symptoms • Fever (≥100.4°F) or chills • Cough • Shortness of breath or difficulty breathing • Fatigue • Muscle or body aches • Headache • New loss of taste or smell • Sore throat • Congestion or runny nose • Nausea or vomiting or diarrhea	• **Test for COVID-19** • Self-isolate pending results of COVID-19 testing • Provider should consider testing for influenza and other common pathogens	• **Positive** COVID-19 test (**Unvaccinated and Fully Vaccinated**[1]): ○ Remain at home except to seek medical care, see Home Isolation and Quarantine Guidance ○ May return to work when **all** the following conditions are met: ▪ 10 days have passed since symptoms first appeared, or if no symptoms, 10 days have passed after positive COVID-19 test was collected **AND** ▪ At least 24 hours with no fever without use of fever-reducing medications **AND** ▪ Symptoms have improved or resolved ○ Employer should **not** require a negative COVID-19 test or clinician's note to return if **all** the conditions above have been met • **Negative** COVID-19 test (**Unvaccinated and Fully Vaccinated**[1]): ○ May return to work if symptoms resolving **and** no fever for 24 hours without use of fever-reducing medications
Close contact with a person with COVID-19 A close contact is defined as being within 6 feet of a person with COVID-19 for 15 minutes or more over a 24-hour period (regardless of mask use) **or** had direct contact with secretions from the person with COVID-19 See Home Isolation and Quarantine Guidance	**Unvaccinated close contact:** • **Test for COVID-19**, even if no symptoms • **Must** quarantine for 10 days[2] after date of last exposure • If continued exposure, **must** quarantine for 10 days[2] after person with COVID-19 finishes isolation **Fully Vaccinated**[1] **Close Contact:** • If no symptoms, **no** quarantine • Test 3–5 days after last contact with person with COVID-19, even if no symptoms **Lab Confirmed COVID-19 in past 90 days:** • If **no** symptoms, **no** quarantine and **no** test	• **Positive** COVID-19 test (**Unvaccinated and Fully Vaccinated**[1]), **see above** • **Negative** COVID-19 test: **UNVACCINATED:** ○ Continue 10-day[2] quarantine period ○ Test again 5–7 days after last contact **or** immediately if you develop symptoms ○ Self-monitor for 14 days after last contact ○ If you develop symptoms, immediately self-isolate and get tested **FULLY VACCINATED**[1]**:** ○ Self-monitor for 14 days after last contact ○ If you develop symptoms, immediately self-isolate and get tested • **Lab Confirmed COVID-19 in past 90 days:** ○ Self-monitor for 14 days after last contact ○ If you develop symptoms, immediately self-isolate and contact your healthcare provider
Illness with low clinical suspicion for COVID-19 **or** **Past medical history of other etiology** (e.g., allergy, asthma)	• **Test for COVID-19** • Provider to use clinical judgement on a case-by-case basis	• **Positive** COVID-19 test (**Unvaccinated and Fully Vaccinated**[1]), **see above** • **Negative** COVID-19 test **or** not tested: ○ May return to work if symptoms resolving **and** no fever for 24 hours without the use of fever-reducing medications

[1] People are fully vaccinated 2 weeks after their second dose in a 2-dose series, such as Pfizer-BioNTech or Moderna, or 2 weeks after a single-dose vaccine, such as Johnson & Johnson's Janssen vaccine.
[2] Quarantine is 14 days for close contacts living or working in congregate settings, including if there are household members who work in congregate settings (e.g., correctional facilities).
Note: If a person with suspected COVID-19 refuses testing, follow guidance for **Positive** COVID-19 test (Unvaccinated or Fully Vaccinated[1]) above.

Updated September 15, 2021

Religious Accommodation Request Form

Part 1: To be completed by employee

Name: ________________________ Department: ____________________

Date of request: __________________________________

Immediate supervisor: ___________________________________

Requested accommodation (job change, schedule change, dress/appearance code exception, vaccination exemption, etc.):

____

____

Length of time the accommodation is needed: _____________________________

Describe the religious belief or practice that necessitates this request for accommodation:

____

____

____

Describe any alternate accommodations that might address your needs:

____

____

____

I have read and understand [Company Name]'s policy on religious accommodation. My religious beliefs and practices, which result in this request for a religious accommodation, are sincerely held. I understand that the accommodation requested above may not be granted but that the company will attempt to provide a reasonable accommodation that does not create an undue hardship on the company. I understand that [Company Name] may need to obtain supporting documentation regarding my religious practice and beliefs to further evaluate my request for a religious accommodation.

Employee signature: _____________________________ Date: ____________________

Part 2: To be completed by the employee's immediate supervisor

Describe the requested accommodation:

____

____

Evaluation of impact (if any): ______________________________________

____

____

Approved: _____________ Denied: _______________

If the requested accommodation is denied, what are some alternative accommodations (list in order of preference):

1. ____

2. ____

3. ____

Date discussed with employee: ______________________________________

Final accommodation agreed upon: ______________________________________

If no agreement on an accommodation, provide an explanation:

____

____

Immediate supervisor: ________________________________ Date: _____________

Manager of immediate supervisor: ________________________ Date: _____________

Human resources director: ______________________________ Date: _____________

Request for Accommodation: Medical Exemption from Vaccination

To request an exemption from required vaccinations, please complete Section 1 below and have your medical provider complete Section 2 before returning this form to the human resources department.

Section 1

Name (print):	Date:
Dept.:	Position:
Manager:	Work/Cell Phone:

I am requesting a medical exemption from [Company Name]'s mandatory vaccination policy for the following vaccination(s):

____

I verify that the information I am submitting to substantiate my request for exemption from [Company Name]'s vaccination policy is true and accurate to the best of my knowledge. I understand that any falsified information can lead to disciplinary action, up to and including termination.

I further understand that [Company Name] is not required to provide this exemption accommodation if doing so would pose a direct threat to myself or others in the workplace or would create an undue hardship for [Company Name].

Employee Signature:	Date:

Section 2

Medical Certification for Vaccination Exemption

Employee Name: ____

Dear Medical Provider,

[Company Name] requires vaccination against [*insert disease name, such as COVID-19, influenza, etc*.) as a condition of employment. The individual named above is seeking an exemption to this policy due to medical contraindications.

Please complete this form to assist [Company Name] in the reasonable accommodation process.

The person named above should not receive the [*insert disease name*] vaccine due to:
This exemption should be: • Temporary, expiring on: __/__/____, or when ___________________________________. • Permanent.

I certify the above information to be true and accurate, and request exemption from the [*insert disease name*] vaccination for the above-named individual.

Medical Provider Name (print):	
Medical Provide Signature:	Date:
Practice Name & Address:	Provider Phone:

HR USE ONLY

Date of initial request: __/__/____

Date certification received: __/__/____

Accommodation request:

- Approved __/__/____

Describe specific accommodation details:

____

- Denied __/__/____

Describe why accommodation is denied:

____