SEATTLE COLLEGES
North · Central · South

1500 HARVARD AVE
SEATTLE, WA 98122
PHONE 206.934.4100
VOICE RELAY 800.833.6388 O WWW.SEATTLECOLLEGES.EDU

VACCINE MEDICAL ACCOMMODATION REQUEST FORM

THIS FORM INCORPORATES THE REQUIREMENTS OF PROCLAMATION 21-14.1 MANDATING A COVID-19 VACCINE FOR STATE EMPLOYEES.

THE PROCLAMATION STATES:

To the extent permitted by law, before providing a disability-related reasonable accommodation to the requirements of this order, individuals or entities for which Health Care Providers work as employees, contractors, or volunteers and State Agencies must obtain from the individual requesting the accommodation documentation from an appropriate health care or rehabilitation professional stating that the individual has a disability that necessitates an accommodation and the probable duration of the need for the accommodation.

What this means:

For a state agency covered by the proclamation to grant a reasonable accommodation to an employee to remain unvaccinated after October 18, 2021, the agency must receive documentation from the employee's medical provider. That documentation must confirm that the employee is medically unable to receive any of the available COVID-19 vaccines. The documentation must also include a duration the accommodation will be needed. *Agencies cannot grant a disability-related accommodation to any employee to remain unvaccinated after October 18, 2021, if they have not received this documentation.*

Instructions for Employees:

1. The employee completes the Release of Information and Vaccination Proclamation Medical Questionnaire Form – Section 1.
2. The employee submits the form and job description to their physician or care provider.
3. The physician or care provider will complete the Vaccination Proclamation Medical Questionnaire Form – Section 2.
4. Once complete, the employee will send a note to hr.vaccine@seattlecolleges.edu, and campus HR will provide you with a secure link to upload the completed form.
    a. Please do **not** send medical information or authorization forms through email.

We would very much appreciate your cooperation by **completing your response no later than October 18, 2021**. If you have any questions, please do not hesitate to contact the HR team at hr.vaccine@seattlecolleges.edu.

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WAIVER AND AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize the release of the following information to Seattle Colleges for the purpose of determining the availability of reasonable workplace accommodations. I further authorize Seattle Colleges to seek clarification of this documentation if necessary by contacting my physician or care provider.

Employee Signature	Date

Check all that are attached:

- ☐ Job Description
- ☐ Job Analysis (Describe)
- ☐ Vaccine Proclamation Medical Questionnaire Form

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VACCINE PROCLAMATION MEDICAL QUESTIONNAIRE

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. 29 CFR § 1635.8(b)(1)(i)(B).

Section 1 (To be completed by employee)

_____
[Name of Health Care Provider]

_____
[Date]

_____
[Address of Health Care Provider]

Re: _____ [Name of employee]

Dear _____[Name of doctor]:

_____[name of employee] is employed with the _____ [name of college] as _____[position] within the_____ [department].

_____[name of employee] has disclosed they have a medical condition or disability which may prevent them from receiving an authorized COVID-19 vaccine.

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We are requesting you complete the following form to help us to understand whether _____[name of employee] has a medical condition or disability which prevents them from receiving an authorized COVID-19 vaccine. I have also enclosed a "Waiver and Authorization To Release Information" form signed by _____ [Name of employee].

Section 2 (To be completed health care provider):

1. Are you a health care or rehabilitation professional?

2. What is your area of practice and/or medical expertise?

3. _____ [name of employee] has disclosed they have a medical condition or disability that may prevent them from receiving an authorized COVID-19 vaccine. Does _____ [name of employee] suffer from such a condition?

   ◯ YES ◯ NO

4. What is the anticipated duration of the medical condition or disability which prevents _____ [name of employee] from receiving an authorized COVID-19 vaccination?

5. In your medical opinion, would a leave of absence be effective in allowing _____ [name of employee] to receive an authorized COVID-19 vaccine so they may return to the full duties of their position at the conclusion of the leave?

   ◯ YES ◯ NO

6. In your medical opinion, if a leave of absence is indicated, what is the anticipated duration of leave required that would permit _____ [name of employee] to be able to receive an authorized COVID-19 vaccine?

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I, Dr. _____ [Name of Health Care Provider], declare that, in my professional opinion, the above responses are true and accurate, to the best of my knowledge and ability.

_____
Signature

_____
Date