# MEDICAL ACCOMMODATION REQUEST FORM – COVID-19 VACCINATION

## COVID-19 VACCINE PROCLAMATION MEDICAL QUESTIONNAIRE

Instructions: Employee takes /sends this questionnaire directly to their medical provider, who returns the completed/signed form to HR, directly. Forms received from persons other than the health care provider will not be accepted.

Name of Health Care Provider: _____

Address of Health Care Provider: _____

Re: Name of employee: _____

Dear [Name of doctor]: _____

Employee, _____, is employed with the San Juan Island School District as (position/title) _____. This employee has disclosed they have a medical condition or disability which may prevent them from receiving an authorized COVID-19 vaccine.

We are requesting you complete the following form to help us to understand whether employee _____ has a medical condition or disability which prevents them from receiving an authorized COVID-19 vaccine. Enclosed is a "Waiver and Authorization to Release Information" form signed by this employee.

Are you authorized to practice in the state of Washington, a state that borders Washington, or the employee's state of residence?

YES ☐ _____ NO ☐ _____

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

_____

When did you begin treating this patient? Date: _____

When is the last time you treated this patient? Date: _____

Employee, _____, has disclosed they have a medical condition or disability that may prevent them from receiving an authorized COVID-19 vaccine. Does this employee have such a condition or disability?

YES ☐ _____ NO ☐ _____

If you responded "yes" to question 3, what is the anticipated duration of the medical condition or disability which prevents Employee, _____, from receiving an authorized COVID-19 vaccination?

_____

In your medical opinion, would a leave of absence be effective in allowing this 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 ☐ _____

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

YES ☐ _____ NO ☐ _____

I, Dr., **_____**, declare that, in my professional opinion, the above responses are true and accurate, to the best of my knowledge and ability.

_____

Signature Date

**Medical Provider:** Please return this form and your response directly to **Cynthia Luna McVeigh, Human Resources Director., San Juan Island School District.** We would very much appreciate your cooperation by completing your response no later than October 18, 2021. Please return your response to the following email address: **cynthiamcveigh@sjisd.org.**

The Authorization to Release Information form, signed by the employee, is attached. If you have any questions, please do not hesitate to contact **Cynthia Luna McVeigh** at **cynthiamcveigh@sjisd.org . Please do not send or include any sensitive medical information if you contact us by email. We can discuss your questions and the method by which you can send your medical information to us, over the phone.**

**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).**