SNOHOMISH SCHOOL DISTRICT
MEDICAL ACCOMMODATION REQUEST FORM – COVID-19 VACCINATION
BACKGROUND

Proclamation 21-14.1 mandates that all school and school district employees become fully vaccinated against COVID-19 or obtain an approved medical or religious accommodation by October 18, 2021 as a condition of continued employment.

> *The Proclamation States:*
> In implementing the requirements of this Order, State Agencies, operators of Educational Settings, and operators of Health Care Settings: …Must, to the extent permitted by law, before providing a disability-related reasonable accommodation to the requirements of this order, 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 school district to grant a reasonable accommodation to an employee to remain unvaccinated after October 18, 2021, the school district must receive the attached COVID-19 Vaccine Proclamation Medical Questionnaire and medical release by **September 8, 2021** to allow time for review by Human Resource Services (HR). *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 of time the accommodation will be needed.*

Employees can expect an interactive process at the beginning of the steps to determine whether the circumstances qualify under the exemption requirements. Then, if the exemption is approved, the employer may need to engage further in the interactive process about whether an effective reasonable accommodation exists to allow them to perform the essential functions of their job. Each case will be evaluated on a case-by-case basis to determine whether or not an effective reasonable accommodation may exist. Following the interactive process, the employee will be notified what accommodations, if any, are available to permit them to continue in their position absent the vaccination.

Employers cannot grant an accommodation related to medical condition or disability to any employee to remain unvaccinated after October 18, 2021 if they have not received this documentation.

Instructions for Employees Seeking a Medical Accommodation

To request a reasonable medical accommodation from the COVID-19 vaccine requirement due to a medical condition or disability, employees must:

- Participate in the district's reasonable medical accommodation request an interactive process.
- Signed and return the attached employee request form (pages 2 and 3) and the medical release form (page 4).
- Obtain the completed questionnaire (pages 5 and 6) from an appropriate medical provider and submit to the HR Office by September 8, 2021. If you are unable to return the completed questionnaire by your medical provider, please contact HR to let them know when you'll be meeting with your medical provider.

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EMPLOYEE REQUEST

Employee, please complete and return to Human Resource Services by September 8, 2021. If you are unable to return the completed COVID-19 VACCINE PROCLAMATION MEDICAL QUESTIONNAIRE, please contact Human Resource Services to let them know when you'll be meeting with your medical provider.

Upon return of the completed employee request form, medical release form, and COVID-19 Vaccine Proclamation Medical Questionnaire, Human Resource Services will be contacting you to schedule a meeting to engage in an interactive dialogue regarding your accommodation request.

Employee Name:			
Phone:		**Building:**	

Please answer the below questions regarding your medical accommodation request:

1. Briefly describe the accommodation you are requesting.

2. If you are not sure what accommodation is needed, do you have any suggestions about what options we can explore?

3. If you are requesting a specific accommodation, how will that accommodation assist you?

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EMPLOYEE REQUEST cont.

4. Please provide any additional medical information that might be useful in processing your accommodation request.

5. Please identify all areas where a six-foot social distancing may not be possible. Please be specific.

6. If the request for accommodation is temporary, please identify the anticipated date the accommodation is no longer needed and why it is temporary.

I certify that I have read and understood the information provided in this request, and that I have truthfully completed it. I understand that this form will be stored separately from my personnel file.

_____ _____

Employee Signature **Date**

Human Resource Services Review

Reviewed By:_____ Date:_____

Accommodation Request (circle one) – Approved / Denied

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EMPLOYEE AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION
(to be completed by employee)

Employee/Patient's Name (printed):_____

I request and authorize_____
[identify individual, institution, or program providing care]

to release health care information and medical records of the patient named above to:

Darryl Pernat
Executive Director of Human Resource Services
Snohomish School District
1601 Avenue D
Snohomish, WA 98290
360-563-7285

This request and authorization applies to health care information or documents regarding any impairment or condition that may limit the patient's ability to receive the COVID-19 vaccination, including information regarding:

- the description and medical facts of the impairment;
- the nature, severity, and extent of the impairment;
- the expected duration of the impairment;
- any activities that the impairment limits and the extent of the limitations;
- any way in which the impairment will affect the patient's ability to perform job functions or equally access employment benefits; and
- any treatment or leave needed due to the condition.

I understand that my express consent is required to release any health care information relating to testing/diagnosis, and/or treatment for HIV (AIDS Virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed, or treated for HIV (AIDS Virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release any health care information relating to such diagnosis, testing, or treatment that falls within the above request and authorization.

This authorization is in effect until _____ (not to exceed ninety calendar days) unless it is earlier revoked.

_____ _____
Employee/Patient Signature Date

SNOHOMISH SCHOOL DISTRICT
MEDICAL ACCOMMODATION REQUEST FORM – COVID-19 VACCINATION
COVID-19 VACCINE PROCLAMATION MEDICAL QUESTIONNAIRE
(to be completed by medical provider)

Name of Health Care Provider:_____

Address of Health Care Provider:_____

Name of Medical Office/Practice:_____

Medical Office Phone Number:_____

Re: (Employee Name)_____

Dear Medical Provider:

The above named employee is employed with the Snohomish School District as a (position/title)_____, and they have 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 questions to help us to understand whether the above named employee has a medical condition or disability which prevents them from receiving an authorized COVID-19 vaccine.

1. Are you authorized to practice in the state of Washington, a state that borders Washington, or the employee's state of residence? YES_____ or NO _____

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

   _____

3. When did you begin treating this patient? Date:_____

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

5. The above named employee has disclosed they have a medical condition or disability that may prevent them from receiving an authorized COVID-19 vaccine. Does the above named employee have such a condition or disability? YES_____ or NO _____

6. If you responded "yes" to question 5, what is the anticipated duration of the medical condition or disability which prevents the above named employee from receiving an authorized COVID-19 vaccination?

   _____

   _____

7. In your medical opinion, would a leave of absence be effective in allowing the above named 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_____ or NO _____

8. In your medical opinion, if a leave of absence is indicated, what is the anticipated duration of leave required that would permit the above named employee to be able to receive an authorized COVID-19 vaccine? YES_____ or 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 of medical provider **Date**

The Authorization to Release Health Care Information form, signed by the employee, is attached. If you have any questions, you may contact Darryl Pernat, Executive Director of Human Resource Services, at 360-563-7285.

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).