WASHINGTON STATE UNIVERSITY

COVID-19 Vaccination Exemption
Medical Accommodation Request
Employee Request and
Health Care Provider Certification

Please return form to:	Human Resource Services (HRS)
Electronic (scan or photo)	HRS.Disabilityservices@wsu.edu
OR Fax:	509-335-1259
Office Location: OR	139 French Administration Bldg.
Mailing address:	PO Box 641014 Pullman, WA 99163
Questions? Call HRS at:	509-335-4521

ACCOMMODATION REQUEST

In accordance with the state of Washington Proclamation 21-14.2 COVID-19 vaccination requirement for state employees, to the extent permitted by law, before providing a disability-related reasonable accommodation to the requirements of this order, employers 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. Agencies cannot grant a medical accommodation to any employee to remain unvaccinated after October 18, 2021, if they have not received this documentation.

Employee completes Sections A through C and the Employee Name field on top of the page 2. The Health Care Provider (HCP) completes Sections D through F. Once form is fully completed, it is to be returned to HRS directly, in order for HRS to review and process your request.

A EMPLOYEE/PATIENT INFORMATION

Name (Last, First, MI)	WSU ID #	Personal Phone
Personal Mailing Address (Street/PO Box, City, State, Zip Code)		Personal Email

B CERTIFY REASON FOR REQUESTING EXEMPTION FROM VACCINE MANDATE

☐ I certify I am requesting an accommodation to be exempted from the state vaccination mandate, as I am a person who has an underlying medical condition and/or disability which prevents me from receiving an authorized COVID-19 vaccine, at this time.

C EMPLOYEE DECLARATION

I understand if my request is incomplete or insufficient, WSU may not authorize the request. I release appropriate HRS personnel to contact my HCP to authenticate or clarify information provided, if necessary.

By signing below, I declare under penalty of perjury under laws of the state of Washington, the foregoing is true and correct and I meet all the requirements necessary for this application associated with State of Washington Proclamation 21-14.2.

Employee Signature	Date

D HEALTH CARE PROVIDER COMPLETES SECTIONS D THROUGH F

The above noted employee has disclosed they have an underlying medical condition and/or disability, which may prevent them from receiving an authorized COVID-19 vaccine.

A complete application and medical certification is required to process a request for an Accommodation under the state of Washington Proclamation 21-14.2 COVID-19 vaccination requirement for state employees mandate. 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 supporting documentation from the employee's health care 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 medical accommodation to any employee to remain unvaccinated after October 18, 2021, if they have not received completed and supporting documentation.

We are requesting you complete the following form to help us to understand whether the employee has a medical condition, which prevents them from receiving an authorized COVID-19 vaccine.

Employee Name (Last, First, MI)

E HEALTH CARE PROVIDER STATEMENT

The above employee has reported they have an underlying medical condition and/or disability that prevents them from receiving an authorized COVID-19 vaccine. Does the employee suffer from such a condition?

☐ Yes ☐ No

If Yes, please continue Section E. If No, please complete Section F - HEALTH CARE PROVIDER DECLARATION and return to HRS.

DURATION OF NEED

In your medical opinion, what is the anticipated duration of the condition, which prevents the employee from receiving an authorized COVID-19 vaccination?

From ____/____/_____ (mm/dd/yy) To ___/____/_____ (mm/dd/yy) OR Other (Please describe below)

LEAVE OF ABSENCE

In your medical opinion, would a leave of absence be effective in allowing the 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

If Yes, in your medical opinion, what is the anticipated duration of leave required that would permit the employee to be able to receive an authorized COVID-19 vaccine?

From ____/____/_____ (mm/dd/yy) To ____/____/_____ (mm/dd/yy) OR Other (Please describe below)

F HEALTH CARE PROVIDER DECLARATION

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

HEALTH CARE PROVIDER NAME (Print or type)	HEALTH CARE PROVIDER SIGNATURE	DATE

HEALTH CARE PROVIDER ADDRESS	CITY, STATE ZIP	
TYPE OF PRACTICE	TELEPHONE	FAX

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 do 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.