MEDICAL EXEMPTION REQUEST FORM - PROCLAMATION 21-14 (VACCINE REQUIREMENT)

September 3, 2021

SHORELINE COMMUNITY COLLEGE will provide reasonable accommodations to qualified applicants and employees with medical disabilities, unless providing such accommodations would pose an undue hardship.

To the extent permitted by law, before providing a disability-related reasonable accommodation to the requirements of Proclamation 21-14.1., the College 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. *The College cannot grant a disability-related accommodation to any employee allowing them to remain unvaccinated after October 18, 2021, if the College has not received appropriate documentation.*

Instructions:
Please provide your responses to the questionnaire below related to your vaccination exemption request because of a medical disability pursuant to Proclamation 21-14.1.

- Please complete and return this form to the **Human Resources Office** no later than **September 17, 2021** to assure timelines for exemption validations are met.
- The completed form can be submitted by the following mechanisms:
  - By email to scchr@shoreline.edu or fax at 206-546-5850 to HR
  - By postal service sent Attn: HR at 16101 Greenwood Ave N. Shoreline WA 98133
- If you have any questions or need more information, please do not hesitate to contact Human Resources at scchr@shoreline.edu at any time.
- NOTE: The HR Office will contact you if additional information or documentation is needed related to your request for medical exemption.

Questionnaire**:**

EMPLOYEE SECTION
Employee Name (print): _____ System ID: _____

Position Title: _____ Program/Area: _____

Medical condition/disability which prevents receiving a COVID-19 vaccine:
_____

_____

Certification Statement:
I certify that I have read and understood the information provided in this request, and that it is true to the best of my knowledge, information and belief.

_____ _____
Employee Signature Date

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MEDICAL PROVIDER SECTION

The purpose of these questions* is to enable the College to verify whether the employee has a medical condition or disability which prevents them from receiving a COVID-19 vaccine.

Health Care Provider Name (print): _____ Area of Practice: _____

Health Care Provider Address: _____

Health Care Provider Phone #: _____ Email: _____

The individual identified on page 1 is employed with the Shoreline Community College under the position and program/area listed. **This employee has disclosed they have a medical condition or disability which may prevent them from receiving an authorized COVID-19 vaccine.**

Shoreline Community College is requesting that your response to the following questions to help us to understand whether the identified employee has a medical condition or disability which prevents them from receiving an authorized COVID-19 vaccine.

1. The employee identified on page 1 has disclosed they have a medical condition or disability that may prevent them from receiving an authorized COVID-19 vaccine. Does the identified employee suffer from such a condition? ☐ **YES** ☐ **NO**

   If yes, what is the medical condition/disability which prevents the employee from receiving a COVID-19 vaccine?

   _____

2. What is the anticipated duration of the medical condition or disability which prevents the identified employee from receiving an authorized COVID-19 vaccination?

   _____

3. In your medical opinion, would a leave of absence be effective in allowing the identified 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**

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

   _____

Certification Statement:

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

Health Care Provider Signature: _____ Date: _____

** 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).*