Employee Request for Reasonable Accommodation from COVID-19 Vaccine

Governor Proclamation 21-14.1 requires employees of the Longview School District ("District") to be fully vaccinated against COVID-19 by October 18, 2021, unless an exception applies. To request a disability-related accommodation to remain unvaccinated against COVID-19, please complete Section 1 below and have your healthcare provider complete Section 2 before returning this form to the Human Resources Department as part of the interactive accommodation process.

Section 1:

Date:	
Name (print):	Position:
Dept:	Supervisor:

I am requesting a disability-related accommodation to remain unvaccinated against COVID-19. After consultation with my doctor, I believe that I have a medical condition that prevents me from receiving the COVID-19 vaccine. I have provided documentation from my doctor of my medical condition, an explanation of why it prevents me from receiving each of the COVID-19 vaccines, and the probable duration of the need for this accommodation.

By signing below, I acknowledge and understand the following:

- Risks of remaining unvaccinated include serious illness or death from COVID-19, including by transmission of disease in the workplace.
- I may be subject to additional safety measures as part of this accommodation, such as requirements for frequent diagnostic testing and additional PPE.
- In the event of an outbreak or threatened outbreak, I may be temporarily excluded or reassigned from District facilities.
- The District is not required to provide an exemption accommodation if doing so would create an undue hardship or pose a direct threat to myself or others in the work environment.
- Any falsified information may lead to disciplinary action, up to and including termination.

I hereby verify as true and accurate the information that I am submitting to substantiate my request for a reasonable accommodation to remain unvaccinated against COVID-19.

Employee Signature:	Date:

Section 2:

Medical Certification for Reasonable Accommodation from COVID-19 Vaccine

Employee Name (print): _____
Employee Job Title: _____

The State of Washington requires that workers in educational settings be fully vaccinated against COVID-19 unless an exception applies. The individual named above ("Patient") is seeking a disability-related accommodation to remain unvaccinated.

Please certify below the medical reason that the Patient should not be vaccinated for COVID-19 by completing this form and attaching available supporting documentation. Information provided on this form will be reviewed during consideration of the accommodation request.

Option 1 – Allergy

☐ A documented history of a severe allergic reaction to any component of a COVID-19 vaccine or to a substance that is cross-reactive with a component. Please indicate which of the following vaccines are contraindicated and name the components, by vaccine. **NOTE:** Because egg-free vaccine is available, history of egg allergy will not be accepted as a routine medical exemption.

- Moderna - List component(s): _____
- Pfizer - List component(s): _____
- Janssen/Johnson & Johnson - List component(s): _____

☐ A documented history of a severe allergic reaction after a previous dose of the COVID-19 vaccine. Please indicate to which vaccine the Patient had a reaction and the date of the vaccine and reaction.

- Moderna - Date of Vaccine and Reaction: _____
- Pfizer - Date of Vaccine and Reaction: _____

Option 2 – Physical Condition/Medical Circumstance

☐ The physical condition of the Patient or medical circumstances relating to the individual are such that vaccination is not medically advisable. Please state, with sufficient detail, the specific nature and probable duration of the medical condition or circumstances that contraindicate vaccination with the COVID-19 vaccine.

Explanation:

Option 3 – Other

☐ Other. Please provide this information in a separate narrative that describes, in detail, the medical condition or disability that you believe should exempt this individual from vaccination and the probable duration of the medical condition or disability:

Explanation:

Certification

The undersigned certifies that the Patient has the above-described medical condition(s) qualifying as a disability and necessitating an accommodation to remain unvaccinated.

This exemption should be:

☐ Temporary, with a probable duration from _____ to _____.

☐ Permanent.

Provider Information

Name: _____

License Number: _____

Specialty: _____

Name of Provider Company: _____

Address: _____

Email: _____

Phone number: _____

Signature: _____

Date: _____