Family Medical Leave and Disability Services
516 High Street, MS 9054
Bellingham, WA 98225-5996
Phone: (360) 650-3774
Confidential Fax: (360) 788-0071

Request for Accommodation: Medical Exemption from Vaccination

Section I: Authorization for Release of Information - For Completion by the EMPLOYEE	
Name:	W#:
I hereby authorize my health care provider to disclose information to WWU regarding my disability status and functional limitations as they are related to my employment. The person and/or institution providing this information is hereby released from all legal responsibility or liability for the release of the below mentioned information. I understand that I have the right to withdraw this authorization at any time and that such revocation must be in writing. Further, I understand that this authorization, without prior revocation, will expire 360 days from the date of signature.	
Signature:	**Date:**

Section II: For Completion by the HEALTH CARE PROVIDER	
The above-named employee has disclosed they have underlying medical condition and/or disability which may prevent them from receiving an authorized COVID-19 vaccine. We are requesting you complete the following form to help us understand whether the employee has a medical condition which prevents them from receiving an authorized COVID-19 vaccine. Please see above for employee's authorization to release information.	
Are you licensed to practice in the state of Washington?	☐ Yes ☐ No
The employee has disclosed they have an underlying medical condition and/or disability that may prevent them from receiving an authorized COVID-19 vaccine. Does the employee suffer from such a condition?	☐ Yes ☐ No
What is the anticipated duration of the condition which prevents the employee from receiving an authorized COVID-19 vaccination?	
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
In your medical opinion if a leave of absence is indicated, what is the anticipated duration of leave required that would permit the employee to be able to receive an authorized COVID-19 vaccine?	

I certify the above information to be true and accurate, and request exemption from the COVID-19 vaccination for the above-named individual.		
Health Care Provider Name	**Signature**	**Date**
Address	**City, State, Zip**	
Type of Practice	**Phone**	**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 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).

Send request to Human Resources (Disability Services), MS 9054 or fax to (360)788-0071.