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

COVID-19 High Risk Employee Medical Questionnaire

Please complete Section I before giving the form to your health care provider. You are responsible for ensuring that Human Resources receives timely and sufficient medical documentation to obtain a reasonable accommodation due to an underlying condition.

Please return this form to Human Resources, not your supervisor.

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 that due to age or an underlying condition as defined by the Centers for Disease Control and Prevention (CDC) they are at high risk of severe illness from COVID-19. The employee has reported they cannot perform the following essential function(s) of their position because of their high risk condition:

- In-person presence at work site

We are requesting you complete the following form to help us understand job-related limitations and to make decisions regarding reasonable accommodation. Please do not include specific information about their condition. Please see above for employee's authorization to release information.

The employee has disclosed that due to age or an underlying condition as defined by the CDC they are at high risk of severe illness form COVID-19. Does the employee suffer from one of these conditions?

☐ Yes
☐ No

Does the condition place the employee at permanent risk of severe illness from COVID-19?

☐ Yes
☐ No

If not, what is the anticipated duration of the risk of severe illness from COVID-19 caused by the condition?

In your medical opinion, does the employee's condition(s) have a substantially limiting* effect on their ability to perform the job functions listed above? OR on their ability to maintain regular and predictable attendance at the work site?

☐ Yes
☐ No

*An effect is substantially limiting if it considerably or to a large degree limits the employee's ability to perform the function. You should examine the restriction as to the condition, manner, or duration under which the individual performs the activity as well as the employee's vaccination status and personal protections available in the workplace.

Please describe, in as specific terms as you can, how the impairment limits this employee's ability to perform those job functions.

Are there steps the employer could take to enable the employee to return to the workplace? ☐ Yes ☐ No

If yes, what steps can be taken?

In your medical opinion, would a leave of absence be effective in allowing the employee to return to the full duties of their position at the conclusion of the leave? ☐ Yes ☐ No

If yes, what is the anticipated duration of leave required that would permit the employee to resume the full duties of their current position?

In your medical opinion, are there any other accommodations that would permit the employee to resume the full duties of their position? ☐ Yes ☐ No

If yes, please list the accommodations:

I certify the above information to be true and accurate, to the best of my knowledge and ability.

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.