STATE OF WASHINGON MEDICAL QUESTIONNAIRE
COVID-19 VACCINE ACCOMMODATION

INSTRUCTIONS FOR USE

THIS FORM INCORPORATES THE REQUIREMENTS OF PROCLAMATION 21-14 MANDATING A COVID-19 VACCINE FOR STATE EMPLOYEES.

THE PROCLAMATION STATES:

To the extent permitted by law, before providing a disability-related reasonable accommodation to the requirements of this order, individuals or entities for which Health Care Providers work as employees, contractors, or volunteers and State Agencies must obtain from the individual requesting the accommodation documentation from an appropriate health care or rehabilitation professional authorized to practice in the State of Washington stating that the individual has a disability that necessitates an accommodation and the probable duration of the need for the accommodation.

What this means:
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 documentation from the employee's medical 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.

Community Colleges of Spokane cannot grant a disability-related accommodation to any employee to remain unvaccinated after October 18, 2021, if Community Colleges of Spokane has not received this documentation.

We would very much appreciate your cooperation by completing your response no later than September 24, 2021. To avoid delay, please feel free to electronically transmit your response to the following fax number: 509-434-5055

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

VACCINE PROCLAMATION MEDICAL QUESTIONNAIRE TEMPLATE

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).

Health Care Provider Name: ____

Health Care Provider Address: ____

__________________________ WA, ____________
City ZIP

Name of Employee/Patient: ____

Your patient is an employee with the Community Colleges of Spokane and has disclosed they have a medical condition or disability which may prevent them from receiving an authorized COVID-19 vaccine. We are requesting you complete the following form to help us to verify and understand whether this employee/patient has a medical condition or disability which, as defined by the state, prevents them from receiving an authorized COVID-19 vaccine.

1. Are you licensed to practice in the state of Washington?

   ☐ Yes ☐ No

2. What is your area of practice and/or medical expertise?

   ____
   ____

3. This employee/patient has disclosed they have a medical condition or disability that may prevent them from receiving an authorized COVID-19 vaccine. Does your patient suffer from such a condition?

   ☐ Yes ☐ No

4. What is the anticipated duration of the medical condition or disability which prevents this employee/patient from receiving an authorized COVID-19 vaccination?

____
____
____

5. In your medical opinion, would a leave of absence be effective in allowing this employee/patient 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

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

____
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____

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

____
Signature

____
Date

Please return this form and your response to:

Grace Leaf, Director of Human Resources
501 N. Riverpoint Blvd, Suite 125
Spokane, WA 99217-6000

We would very much appreciate your cooperation by completing your response no later than September 24, 2021. To avoid delay, please feel free to electronically transmit your response to the following fax number: 509-434-5055

If you have any questions, please do not hesitate to contact Grace Leaf at 509-434-5031 or Grace.Leaf@ccs.spokane.edu

Please do not send or include any sensitive medical information if you contact us by email. We can discuss your questions and the method by which you can send your medical information to us, over the phone.