STATE OF WASHINGTON
OFFICE OF GOVERNOR JAY INSLEE

PROCLAMATION 21-14, *et seq.*
DISABILITY-RELATED EXEMPTION REQUEST FORM

DISCLAIMER. *This template is meant to be a reference for Washington employers processing disability-related (medical) exemptions under Proclamation 21-14, et seq. The state makes no representation that reliance on this template will satisfy an employer's legal obligations or shield any employer from legal challenges. Every employment setting is unique, and you should carefully review your accommodation policies with legal counsel. In providing this template, the state is not requiring its use by private employers; rather, it is intended for Washington state agencies and is offered for general informational purposes only.*

Sections specific to state agencies are highlighted to help employers avoid mislabeling their forms.

INSTRUCTIONS FOR USE

THIS FORM INCORPORATES THE REQUIREMENTS OF PROCLAMATION 21-14, *et seq*., 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. *Agencies cannot grant a disability-*

related accommodation to any employee to remain unvaccinated after October 18, 2021, if they have not received this documentation.

THIS FORM SHOULD BE MODIFIED TO FIT THE PARTICULAR FACTS OF YOUR SITUATION. THE QUESTIONS BELOW ARE MERELY AN INITIAL GUIDELINE. When making substantive changes, please work with your labor and personnel assistant attorney general.

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.

Do not remove the Genetic Information Nondiscrimination Act of 2008 (GINA) "safe harbor" language that appears in bold just below the date in the template, although you may choose to place it in another prominent location in the letter/questionnaire.

VACCINE PROCLAMATION MEDICAL QUESTIONNAIRE TEMPLATE

[Insert 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).

[Insert name of Health Care Provider]
[Insert address of Health Care Provider]

Re: **[Insert name of employee]**

Dear **[Insert name of doctor]:**

[Insert name of employee] is employed with the **[insert name of agency]** as **[insert position]** within the **[insert division/administration if relevant]**.
[Insert name of employee] 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 understand whether **[insert employee's name]** has a medical condition or disability which prevents them from receiving an authorized COVID-19 vaccine. I have also enclosed a "Waiver and Authorization To Release Information" form signed by **[insert name of employee]**.

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

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

3. **[Insert name of employee]** has disclosed they have a medical condition or disability that may prevent them from receiving an authorized COVID-19 vaccine. Does [**Insert name of employee**] suffer from such a condition?

_____YES _____NO

4. What is the anticipated duration of the medical condition or disability which prevents **[Insert name of employee]** from receiving an authorized COVID-19 vaccination?

5. In your medical opinion, would a leave of absence be effective in allowing **[insert name of 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

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

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 **[insert name and mailing address of employing agency]**. We would very much appreciate your cooperation by completing your response no later than **[insert date]**. To avoid delay, please feel free to electronically transmit your response to the following fax number: **[insert fax number]**.

If you have any questions, please do not hesitate to contact **[insert name of responsible agency personnel]** at **[insert phone number(s), or at email address(es)]. 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.**

Check all that are attached:
- □ Job Description
- □ Job Analysis (Describe)
- □ Employee's Authorization to Release Medical