COVID-19 Vaccine Requirement
Request for Reasonable Accommodation – ADA/Medical Reasons

In accordance with City of Bellingham Executive Order 2021-02, the City of Bellingham (the "City") has made COVID-19 vaccination a condition of employment for all City employees.

Please complete this form if you have a medical reason why you cannot obtain the COVID-19 vaccine and would like to request a reasonable accommodation pursuant to the Americans with Disabilities Act. Requests for reasonable accommodations will be considered upon receipt of a completed form, signed and certified by a licensed health care provider, whose specialty is appropriate to the associated condition.

Requests for reasonable accommodations will be evaluated on a case-by-case basis. While the City will carefully review all requests for accommodations in an interactive manner, approval is not guaranteed. After your request has been reviewed and processed, you will be notified, in writing, if an accommodation has been granted or denied. If the approved accommodation contains an expiration, you will be expected to complete the requirement at that time. Should the condition continue, or a new vaccination contraindication occur, a new request with updated documentation is required. Individuals whose requests have been denied are permitted to reapply if new documentation and information should become available.

ADA/Medical reasonable accommodation request process:

- Read the Key Things to Know About COVID-19 Vaccines (cdc.gov)
- Complete and sign the following page of this form;
- Have your Licensed Health Care Provider complete the provider section of this form;
- Submit the completed documents.

Please initial next to each of the statements below:

	I request a reasonable accommodation based on a medical condition or disability. I understand and assume the risks of non-vaccination. I accept full responsibility for my health, thus removing liability from the City for the required vaccination.
	Should I contract COVID-19, I will immediately report it to my supervisor and will comply with all isolation and quarantine procedures as recommended by Washington State and the CDC.
	I acknowledge that I have read the Key Things to Know About COVID-19 Vaccines (cdc.gov).
	I understand that if I am granted a reasonable accommodation, it will expire when the medical condition(s) contraindicating vaccination changes in a manner which permits vaccination, as determined by the City in reviewing the request.
	I understand and agree to comply with and abide by all of the City's COVID-19 policies and procedures.
	I understand that if an accommodation is granted, it is only valid while the Washington State and the City COVID-19 vaccination policy stands and I may need to submit a new request for any subsequent changes, new medical contraindications, or upon expiration of an approved accommodation. I further understand that the approval is provisional based on the current vaccination policy and is subject to change based on the City's requirements moving forward.
	I authorize my licensed health care provider to provide the City with medical information about my disability or medical condition that prevents me from obtaining the COVID-19 vaccination.
	I certify that the information I have provided in connection with this request is accurate and complete as of the date of this submission. I understand this accommodation may be revoked and I may be subject to disciplinary action if any of the information I provided in support of this exemption is false.

Please state what specific accommodation(s) you feel are needed. Please attach additional documentation, if necessary.

_____
_____
_____
_____
_____
_____

Printed Name: _____
Signature: _____
Date: _____

☐ By checking this box and typing my name above, I understand and agree that I am submitting this document electronically and that it is the legal equivalent of having placed my handwritten signature on the submitted document.

Date: _____

Attention Health Care Provider:

In accordance with City of Bellingham Executive Order 2021-02, the City of Bellingham (the "City") has made COVID-19 vaccination a condition of employment for all City employees. _____ (insert patient's name) is requesting a reasonable accommodation due to a medical condition or disability.

Please certify below the medical reason that your 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 in consideration of the accommodation request. *Please note that according to a Joint Statement from the American Board of Family Medicine, providing misinformation about the COVID-19 vaccine contradicts physicians' ethical and professional responsibilities, and therefore may subject a physician to disciplinary actions, including suspension or revocation of their medical license*.[1]

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: since egg free vaccine is available, history of egg allergy will not be accepted as basis for a reasonable accommodation.

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

☐ A documented history of a severe allergic reaction after a previous dose of the COVID-19 vaccine.

- Moderna - Date of Vaccine & Reaction: _____
- Pfizer - Date of Vaccine & 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 considered safe. Please state, with sufficient detail for independent medical review, the specific nature and probable duration of the medical condition or circumstances that contraindicate vaccination with the COVID-19 vaccine.

Explanation:

[1] The Joint Statement is available here: https://www.theabfm.org/about/communications/news/joint-statement-american-board-family-medicine-american-board-internal rd of Pediatrics on Dissemination of Misinformation by Board Certified Physicians about COVID-19 | ABFM | American Board of Family Medicine (theabfm.org)

Option 3 - Other

☐ Other. Please provide this information in a separate narrative that describes, in detail, the medical condition or disability in detail that you opine would require this individual to need an accommodation from vaccination:

Explanation:

Certification

I certify that_____(patient name) has the above contraindication and support the request for a medical accommodation from the COVID-19 vaccine requirement at the City of Bellingham.

Provider Information

Medical Provider Name: _____

Medical Provider Specialty: _____

Signature: _____

Provider License Number: _____

Date: _____

Name of Provider Company: _____

Address: _____

Email: _____

Phone number:_____

Patient Information

Patient Name: _____

Date: _____