Mandatory COVID 19 Vaccination Employee Request for Reasonable Accommodation Form - Medical Condition or Disability

All City of Shoreline employees must be fully vaccinated against COVID-19 by December 1, 2021. City of Shoreline employees subject to Governor Inslee's Emergency Proclamation 21-14.1 COVID-19 Vaccination Requirement, shall be fully vaccinated against COVID-19 by October 18,2021. It is the policy of the City of Shoreline to provide reasonable accommodations in compliance with laws protecting individuals with disabilities for any known medical condition or disability which prevents an employee from being fully vaccinated against COVID-19 as required by this Policy. You will be required to provide documentation in support of your request for reasonable accommodations.

This form is intended to assist the City of Shoreline in assessing any request for an accommodation or exemption from being vaccinated against COVID-19 based upon a medical condition or disability. To request a medical accommodation from the City of Shoreline's COVID-19 vaccination requirement:

1. The employee must complete Part 1 of this form;
2. The employee's medical care provider must complete Part 2; and
3. When both are completed, the employee must submit the form to the Human Resources and Organizational Development Director.

Human Resources (HR) will engage in an interactive process to determine whether the employee is eligible for an accommodation based on the information provided and consistent with the City of Shoreline's Reasonable Accommodation Procedures. Medical information will be kept in a separate medical file, in a location that is accessible only to authorized personnel, and will remain confidential to the extent permitted by law.

Part 1 – To be Completed by the Employee		
Employee Name:	Date of Request:	
Department:	Division:	
Position:	Supervisor:	Date:

Medical or Disability Accommodation Request and Employee Certification:	
I have a disability or medical condition that prevents me from receiving any COVID-19 vaccine. To be eligible for this exemption and accommodation, I understand that I must also provide a written medical certification signed and certified by a licensed medical care provider and whose specialty is appropriate to the associated condition, stating that I qualify for the accommodation and indicating the probable duration of my inability to receive the vaccine (but the written medical certification should **NOT** identify the underlying medical condition or disability itself). I have received and reviewed information on the City Policy requiring COVID-19 vaccination. I understand that a detailed review of my disability status may be required, and I agree to cooperate fully in this process. I further understand that if my request is approved, I am obligated to report any changes in my status which may require a re-evaluation of this request. Granting of this request does not signify approval of any future reasonable accommodation request for any other position within the City. I understand that this exemption is only valid while the City COVID-19 vaccination policy stands and I may need to submit a new request for any subsequent changes, new medical contraindications, or on expiration of an approved exemption. I further understand that the approval is provisional based on the current vaccination policy and is subject to change based on the City requirements moving forward. I further understand that the City is not required to provide this exemption accommodation if doing so would pose a direct threat to myself or others in the workplace or would create an undue hardship. I hereby verify and certify that I make this request based on my belief that I have a disability or medical condition that prevents me from complying with the City's COVID-19 vaccination policy. I understand that any falsified information or intentional misrepresentation can lead to disciplinary action, up to and including termination of employment.	
Employee Signature:	
Print Name:	Date:

Part 2 – To be Completed by the Employee's Medical Care Provider:

Employee Name:

Medical Certification for COVID-19 Exemption:

Dear Medical Provider:

The City of Shoreline requires all of its employees to be fully vaccinated against COVID-19. The individual named above is seeking an accommodation(s) from this policy due to medical circumstances. Please compete the below form to assist the City of Shoreline in the reasonable accommodation process.

Please provide at least the following information where applicable:

1. The applicable CDC contraindication for the COVID-19 vaccine;
2. The applicable contraindication found in the manufacturer's package insert for the COVID-19 vaccine;
3. A statement that the physical condition of the person or medical circumstances relating to the person are such that the COVID-19 immunization is not considered safe, indicating with sufficient detail for independent medical review the specific nature and probable duration of the medical condition or circumstances or disability, if any, that contraindicate immunization with the COVID-19 vaccine; and
4. Any other medical condition, including the objective medical reasons, which would prevent the employee from receiving the COVID-19 vaccine.

CDC Contraindications and Precautions to COVID-19 Vaccines: https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html#Contraindications

CDC Vaccine Recommendations and Guidelines of the ACIP: ACIP Contraindications Guidelines for Immunization | CDC

Description of the medical condition or disability for which the employees listed above should be exempted from complying with City of Shoreline's COVID-19 vaccine Requirement:

The condition described above is:	☐ temporary	☐ permanent

If this is a temporary condition, when will it end or expire:

I am a physician (MD or DO) licensed to practice medicine in Washington State or an advanced registered nurse practitioner licensed in Washington State.

By signing below, I affirm that I have reviewed the current CDC/ACIP Contraindications and Precautions for the COVID-19 vaccine and affirm that the stated contraindication(s)/precautions(s) shown above is enumerated by the CDC/ACIP and consistent with established national standards for vaccination practices. I understand that I may be required to submit supporting medical documentation:

Medical Provider Name/Title: _____

Medial Provider Phone Number: _____

Medical Provider Signature: _____

Date: _____