Request and Medical Certification for Reasonable Accommodation Regarding the COVID-19 Vaccination Due to Medical Condition(s)/Pregnancy-Related Concern(s)

Section 1: To be Completed by the **Employer**

Employer name and contact: _____

Employee name: _____ Employee's Title: _____

Employee's essential job functions (or attach job description): _____

Description of Policy (or attach email/memo): We have a mandatory COVID-19 vaccination policy, but we provide reasonable accommodations to those eligible for them. Your patient has requested reasonable accommodations for the COVID-19 vaccination requirement due to disability or pregnancy concerns. Sufficient medical certification is required as part of our interactive process for considering such requests.

Response from Health Care Provider is due (usually 15 calendar days): _____

Section 2: To be Completed and Signed by the **Employee**

I understand that my request for reasonable accommodation must be supported by a timely-provided, complete, and sufficient medical certification from a health care provider who is treating me for my pregnancy concerns and/or medical condition(s) relevant to the COVID-19 vaccine requirement, and if I fail to provide it, my request may be denied. By my signature below, I waive confidentiality protections under HIPAA and other laws and I authorize my health care provider to provide the information requested to my employer.

Employee's Signature: _____ Date: _____

Section 3: To be Completed and Signed by the **Health Care Provider**

Your patient requested reasonable accommodations from our mandatory COVID-19 vaccine requirement due to expressed pregnancy concerns or their own medical condition(s). We require supporting medical certification to show that the COVID-19 vaccination is contraindicated for this patient and to support your recommendation that they not receive the COVID-19 vaccination. Please answer all applicable parts of Section 3 fully and completely. When asked about the frequency or duration of a condition or treatment, use your best estimate based on your medical knowledge, experience, and examination of the patient. Be as specific as you can. **All information provided should be based on current CDC recommendations regarding COVID-19**. Certify and sign the form on the last page (the signature cannot be that of an office staff person).

Please be sure to limit your response to the condition(s) for which your patient is seeking reasonable accommodations regarding the COVID-19 vaccine.

We are obligated to advise you that the Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers from requesting or requiring genetic information of employees or their family members. In order to comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic

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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.

Provider's name and business address: _____

Type of practice/Medical specialty: _____

Telephone: _____ Fax number: _____

Part A: Certification of Medical Condition(s) or Pregnancy Concern(s) Contraindicating COVID-19 Vaccination

1. Do you recommend the COVID-19 vaccination for this patient? ___ No ___ Yes

If "yes," skip to the certification and signature section.
If "no," complete the rest of this form, including the certification and signature.

2. List medical condition(s) that contraindicate the COVID-19 vaccination for this patient: _____

_____

3. Approximate date of onset of condition(s) in Question 2: _____

4. Dates you treated the patient since March 15, 2020 for the condition(s) in Question 2: _____

_____

5. Probable duration of condition(s) in Question 2: _____

6. Is/Are the condition(s) in Question 2: Stable, Subject to Change over Time, or Progressive?
(circle the correct answer; if each condition has a different answer, provide additional information in Section D)

7. Describe the current severity of the condition(s) in Question 2: _____

_____

8. List at least one major life activity, or the operation of at least one major bodily function, that is substantially limited by the employee's condition(s) in Question 2 (see Definitions on last page):

_____

9. List any side effects of medication or treatments that have been prescribed for the condition(s) in Question 2 and indicate whether any substantially limits the employee's ability to engage in major life activities or the operation of a major bodily function: _____

_____

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10. If the condition(s) in Question 2 is/are pregnancy or is/are related to pregnancy, list the expected delivery date or describe the pregnancy-related condition: _____

_____

Part B: COVID-19 Vaccine Recommendation and Medical Certification

11. Would inoculation with the COVID-19 vaccine pose a "direct threat" (see Definitions) to the safety or health of the patient? ___ No ___ Yes

12. Does the patient have a documented history of severe allergic reaction to any component of a COVID-19 vaccine, to a substance that is cross-reactive with such a component, or to an initial dose of the Pfizer or Moderna vaccine? ___ No ___ Yes

Click here for vaccine ingredients. Egg-free vaccine is available.

If yes, indicate which vaccines are contraindicated for the patient and name the components of the vaccine to which they are severely allergic.

Pfizer _____

Moderna _____

Janssen/Johnson & Johnson _____

13. How would inoculation with the COVID-19 vaccine otherwise negatively impact the patient with respect to the condition(s) identified in Question 2? _____

_____

14. List any additional medical facts supporting your recommendation that this patient should not be inoculated with the COVID-19 vaccine. _____

_____

Part C: Accommodations

15. Are there any accommodations that would allow the patient to perform the essential functions of their job, without receiving the COVID-19 vaccine, that would also, at the same time, fulfill the organization's obligation to provide all employees with a work environment "free from recognized hazards that are causing or are likely to cause death or serious physical harm" (Safe Workplace)?

___ No ___ Yes

If "yes," answer questions 16-17. If "no," skip questions 16-17.

16. What suggestions do you have for accommodations that might allow the patient to perform the essential functions of their job without being fully vaccinated, and allow the organization to maintain a Safe Workplace? Include the period of time over which the reasonable accommodation will be needed.

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Accommodation Suggestion **Time Needed**

Suggestions contrary to CDC Guidelines, or laws applicable to the employer (e.g., OSHA, CMS, EO 14042, cannot be provided.

❒ Wear a face covering in assigned worksites _____

❒ Socially distance from others in assigned worksites (6' or more of distance) _____

❒ Periodically provide proof of negative COVID-19 tests _____

❒ Modify the work schedule _____

❒ Short leave of absence until condition(s) change to permit vaccination _____

Explain what changes would be needed to permit vaccination and a return to work

_____

❒ Work remotely (from home) _____

❒ Eliminate work where vaccination is required (job restructuring) _____

❒ Reassign to a vacant position where vaccination is not required _____

❒ Other (describe below) _____

_____

❒ Deferral for _____ (time) due to _____

_____ (reason)

17. Is complete exemption from the mandatory COVID-19 vaccination rule the only medical option for this patient? ___ No ___ Yes

Part D: Additional Information and Signature

Provide any additional information related to the patient's condition(s) and its impact on inoculation with the COVID-19 vaccine. If additional space was needed to answer any of the questions above, you may provide that information here; identify the question number to which the additional information is related.

_____

_____

Certification

- I certify that the information provided above, in Section 3 of this form, is accurate and truthful.
- I certify that it is my professional medical opinion that the patient named above has the medical condition(s) and limitation(s)/restriction(s) indicated, and needs the suggested accommodation(s).
- I understand that if this information has been provided without a legitimate medical basis it is a breach of my ethical duties as a licensed health care provider and may be reported to the applicable state medical licensing board(s).

_____ _____

Signature of Health Care Provider Date

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DEFINITIONS

"COVID-19 vaccination" means a biological product authorized or licensed for emergency or regular use by the FDA to prevent or provide protection against the respiratory disease caused by SARS-CoV-2, administered in such a manner as to provide full vaccination coverage, as recommended by the CDC and/or FDA at the time this form was completed.

"Direct threat" means a significant risk of substantial harm to the health or safety of the individual or of others that cannot be eliminated or reduced by reasonable accommodation. The determination that an individual poses a "direct threat" shall be based on an individualized assessment of the individual's present ability to safely perform the essential functions of his/her job. **This assessment shall be based on a reasonable medical judgment that relies on the most current medical knowledge and/or on the best available objective evidence**. In determining whether an individual would pose a direct threat, the factors to be considered include: (1) the duration of the risk; (2) the nature and severity of the potential harm; (3) the likelihood that the potential harm will occur; and (4) the imminence of the potential harm. *See* 29 C.F.R. § 1630.s(r). **The risk must be current, not speculative and remote**. Do not speculate on whether the individual's disability may become more or less severe in the future.

"Substantially limits" means the condition substantially limits the ability of an individual to perform a major life activity as compared to most people in the general population. An impairment need not prevent, or significantly or severely restrict, the individual from performing a major life activity in order to be considered substantially limiting. The determination of whether an impairment substantially limits a major life activity shall be made without regard to the ameliorative effects of mitigating measures (such as medication, medical supplies, equipment, or appliances, low-vision devices, prosthetics, hearing aids, cochlear implants or other implantable hearing devices, mobility devices, oxygen therapy equipment and supplies, use of assistive technology, reasonable accommodations or auxiliary aids or services that can be provided or implemented, learned behavioral or adaptive neurological modifications, physical therapy, psychotherapy, or behavioral therapy, or physical therapy). However, the ameliorative effects of ordinary eyeglasses or contact lenses shall be considered in determining whether an impairment substantially limits a major life activity. If a condition is episodic or in remission, consider whether the individual is substantially limited in a major life activity when the condition is active. *See* 29 C.F.R. § 1630.2(j)

Non-Exhaustive Examples of "Major Life Activities"

- Caring for oneself
- Performing manual tasks
- Seeing
- Hearing
- Eating
- Sleeping
- Walking
- Standing
- Sitting
- Reaching
- Lifting
- Bending
- Speaking
- Breathing
- Learning
- Reading
- Concentrating
- Thinking
- Communicating
- Interacting with others
- Working

Non-Exhaustive Examples of "Major Bodily Functions"

- Immune system
- Special sense organs and skin
- Normal cell growth
- Digestive
- Genitourinary
- Bowel
- Bladder
- Neurological
- Brain
- Respiratory
- Circulatory
- Cardiovascular
- Endocrine
- Hemic
- Lymphatic
- Musculoskeletal
- Reproductive functions
- The operation of an individual organ within a body system

See 29 C.F.R. § 1630.2(i)

"Reasonable Accommodations" means modifications or adjustments to the work environment, or to the manner or circumstances under which the job is customarily performed, that enable an employee to perform the essential functions of that job. A few examples of reasonable accommodations include making the facility accessible, job restructuring, part-time or modified work schedule, reassignment to a vacant position, acquisition or modifications of equipment or devices; appropriate adjustment or modifications of examinations, training materials, or policies, the provision of qualified readers or interpreters, and other similar accommodations. *See* 29 C.F.R. § 1630.2(o).

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