COVID-19 Vaccination
Medical Accommodation Form

Harmony Healthcare INTERNATIONAL

To request an exemption from [Company Name]'s COVID-19 vaccination requirement due to a medical condition or disability, please complete Section 1 below and have your medical provider complete Section 2. Return the completed form to [NAME/TITLE/DEAPRTMENT].

Section 1

Name (print): ______________________________

Position: ____________________ Department: ____________________

I am requesting a medical exemption from the company's COVID-19 vaccination requirement. I verify that the information I am submitting to substantiate my request is true and accurate to the best of my knowledge. I understand that any falsified information can lead to disciplinary action, up to and including termination of employment.

I further understand that [Company Name] is not required to provide this exemption as an accommodation if doing so would pose a direct threat to myself or others in the workplace or create an undue hardship for the company.

______________________________ ____________________

Employee Signature Date

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Section 2

Medical Certification for COVID-19 Vaccination Exemption

Employee Name (Patient Name): ____

Dear Medical Provider,

[Company Name] requires employees to be fully vaccinated against COVID-19 as a condition of employment. The individual named above is seeking an exemption to this policy for medical reasons.

Please complete this form to assist us in the reasonable accommodation process.[1]

1. Does your patient (our employee) have a sensory, mental, or physical impairment that is medically cognizable or diagnosable, which makes it medically inadvisable for the patient to receive a COVID-19 vaccine at this time?

   Yes ☐ No ☐

*(For the purposes of this questionnaire, "**impairment**" includes, but is not limited to:*

(i) Any physiological disorder, or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological, musculoskeletal, special sense organs, respiratory, including speech organs, cardiovascular, reproductive, digestive, genitor-urinary, hemic and lymphatic, skin, and endocrine; or

(ii) Any mental, developmental, traumatic, or psychological disorder, including, but not limited to, cognitive limitation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.)

If **yes**, please identify the impairment.

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If you answered yes to question one (1), skip question two (2) and answer question three (3).

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[1] The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. 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.

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2. If you answered **no** to question one (1), is there a medical reason (e.g., pregnancy) why the employee

3. should not receive a COVID-19 vaccine at this time?

   Yes ☐ No ☐

   If your answer is **yes**, please explain the medical reason why the employee should not receive the COVID-19 vaccine at this time.

   ____

   ____

   ____

4. If you answered **yes** to question one (1) or two (2), is there a time in the future when it would be medically safe for the patient to receive the COVID-19 vaccine?

   Yes ☐ No ☐

   If **yes**, please list the approximate date the employee will be able to receive a COVID-19 vaccine.

   ____

I certify that I am a health care or rehabilitation professional authorized to practice in the State of Washington. I further certify that the above information is true and accurate, and recommend that the above-named individual be exempted any requirement to receive a COVID-19 vaccine at this time.

____

Medical Provider Name (print)

____ ________________________

Medical Provider Signature **Date**

____ ________________________

Practice Name & Address **Provider Phone**

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