SPOKANE PUBLIC SCHOOLS VOLUNTEER

DISABILITY/MEDICAL ACCOMMODATION REQUEST FORM - COVID-19 VACCINATION

Instructions: Please complete this form in its entirety. If you have any questions, please contact Jason Lesley in Human Resources at JasonL@spokaneschools.org or by phone: 509-354-7262.

A volunteer who maintains a disability/medical condition that prevents them from being vaccinated against COVID-19 may request an accommodation (e.g., delay in vaccination, change in non-essential job duties, transfer, leave of absence, etc.). Employees requesting an accommodation must provide supporting documentation from a health care or rehabilitation professional.

Completed by Employee Requesting Accommodation:

Name (print):	Date:
Volunteer Location	Volunteer Phone Number:
Volunteer email address:	

I verify that the information I am submitting to substantiate my request for exemption from the COVID-19 vaccination requirement is true and accurate to the best of my knowledge. I understand that any falsified information can lead to denial of requested volunteer services. If additional information is needed, I authorize Spokane Public Schools to contact my medical/health care provider.

Volunteer Signature:	Date:

Completed by a Health Care/Medical Provider:

We are requesting you complete the following form for the above-named employee to help us understand whether the above-named individual has a medical condition or disability which prevents them from receiving a COVID-19 vaccine.

Are you authorized to practice in the state of Washington, a state that borders Washington, or the employee's state of residence?

Yes_____ No_____

What is your area of practice and/or medical expertise?:_____

When did you begin treating this patient? Date:_____ When was the last date you treated this patient? _____

The above-named individual has a disability/medical condition that prevents the employee from being fully vaccinated against COVID-19. Check one below.

☐This accommodation is permanent/lasting OR

☐This accommodation is temporary. If temporary, please indicate the probable duration needed for the accommodation or the specific end date if known: _____

I, declare under penalty of perjury that, in my professional opinion, the above responses are true and accurate to the best of my knowledge and ability, and I hereby request exemption from the COVID-19 vaccination for the above-named individual.

Health Professional Name (print):	
Health Professional Signature:	Date:
Practice Name & Address:	Health Professional Contact Number:

MEDICAL/HEALTH CARE PROVIDER: Please return this form and your response to Jason Lesley in Human Resources. Please return your response to the following email address JasonL@spokaneschools.org or fax number 509-354-5963.

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 family 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 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).

HR USE ONLY

Date of initial request: __/__/____ Date certification received: __/__/____

Accommodation request:

- ☐ Approved __/__/_____ by:_____

Describe specific accommodation details:

_____

- ☐ Denied __/__/____ by:_____

Describe why accommodation is denied:

_____