EASTERN WASHINGTON UNIVERSITY

VACCINE WAIVER REQUEST MEDICAL QUESTIONNAIRE

Date:_____

Employee's Name: _____ Employee's Position: _____

Health Care Provider's Name: _____

Health Care Provider's Address: _____

_____

Employee has disclosed they have a medical condition or disability which may prevent them from receiving an authorized COVID-19 vaccine.

Please complete this form to help us to understand whether Employee has a medical condition or disability which prevents them from receiving an authorized COVID-19 vaccine.[1] Also enclosed is a "Waiver and Authorization to Release Information" form signed by Employee.

1. Are you licensed to practice in the state of Washington?
   Yes ◯ No ◯
2. What is your area of practice and/or medical expertise?
3. Employee has disclosed they have a medical condition or disability that may prevent them from receiving an authorized COVID-19 vaccine. Does Employee suffer from such a condition?
   Yes ◯ No ◯
4. What is the anticipated duration of the medical condition or disability which prevents Employee from receiving an authorized COVID-19 vaccination?

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[1] **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 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. 29 CFR § 1635.8(b)(1)(i)(B).**

EASTERN WASHINGTON UNIVERSITY

5. In your medical opinion, would a leave of absence be effective in allowing Employee to receive an authorized COVID-19 vaccine so they may return to the full duties of their position at the conclusion of the leave?

   Yes ◯ No ◯

6. In your medical opinion, if a leave of absence is indicated, what is the anticipated duration of leave required that would permit Employee to be able to receive an authorized COVID-19 vaccine?

I, Dr. _____, declare that, in my professional opinion, the above responses are true and accurate, to the best of my knowledge and ability.

Signature _____

Date _____

Please return this form and your response to Eastern Washington University, Human Resources, 314 Showalter Hall, Cheney, WA 99004. We would very much appreciate your cooperation by completing your response no later than five days after receipt. To avoid delay, please feel free to electronically transmit your response to the following fax number: 509-359-2874.

If you have any questions, please do not hesitate to contact Caren Lincoln, Senior Director of Human Resources at 509-359-2383 or at email clincoln@ewu.edu. Please do not send or include any sensitive medical information by email. We can discuss your questions and the method by which you can send your medical information to us, over the phone.

Check all that are attached:

- ☐ Job Description
- ☐ Job Analysis (Describe)
- ☐ Employee's Authorization to Release Information

EASTERN WASHINGTON UNIVERSITY

Waiver and Authorization to Release Information

Name of Employee: _____ Date of Birth: _____

Job Title: _____ Department: _____

Work Schedule: _____

Name of Health Care Provider: _____

Health Care Provider Address: _____

Health Care Provider Phone: _____

I hereby authorize the above listed health care provider and any others who have treated me to release to Eastern Washington University the following information related to my health care: diagnosis of relevant condition(s), the severity and duration of the impairment, my ability to perform my work with or without reasonable accommodation, and information as to why the requested reasonable accommodation is needed. I also authorize disclosure and discussion as necessary so that EWU may determine appropriate and reasonable accommodations for me. I understand that information obtained under this release is a confidential medical record and is maintained separately from my personnel file. This authorization is valid for a period of ninety (90) days after signature.
I further understand that, if I have a qualifying disability, EWU is not obligated to provide any specific accommodation I request, but will evaluate all information gathered through an interactive process with me and otherwise to make a determination of what is a reasonable accommodation regarding a vaccine waiver.

Employee Signature: _____ Date: _____