

COVID-19 Vaccination Exemption
 Medical Accommodation Request
 Volunteer Request and
 Health Care Provider Certification

Electronic (scan or
 photo)

FAX: 509-335-1065

OR Mailing address:

PO Box 646242 Pullman, WA
 99164-6242

Questions? Call WSU
 Extension at:

Phone: 509-335-4561

ACCOMMODATION REQUEST

In accordance with the State of Washington August 20, 2021 [Proclamation 21-14.1](#) COVID-19 vaccination requirement, to the extent permitted by law, before providing a disability-related reasonable accommodation to the requirements of this order, WSU Extension must obtain from the individual requesting the accommodation, documentation from an appropriate health care or rehabilitation professional stating that the individual has a disability that necessitates an accommodation and the probable duration of the need for the accommodation. WSU cannot grant a medical accommodation to any volunteer to remain unvaccinated and being in active volunteer status after October 18, 2021, if they have not received this documentation. This form must be submitted at least one month prior to the date the volunteer would like to be in active status.

Volunteer completes Sections A through C and the Volunteer Name field on top of the page 2. The Health Care Provider (HCP) completes Sections D through F. Once form is fully completed, it is to be returned to WSU Extension directly, in order for WSU Extension to review and process your request.

A VOLUNTEER/PATIENT INFORMATION

Name (Last, First, MI)		Phone Number	Email
Mailing Address (Street/PO Box, City, State, Zip Code)		County: _____	
		Program: _____ (Master Gardener, 4-H, Other {name})	

B CERTIFY REASON FOR REQUESTING EXEMPTION FROM VACCINE MANDATE

I certify I am requesting an accommodation to be exempted from the state vaccination mandate, as I am a person who has an underlying medical condition and/or disability which prevents me from receiving an authorized COVID-19 vaccine, at this time.

C VOLUNTEER DECLARATION

I understand if my request is incomplete or insufficient, WSU may not authorize the request. I release appropriate HRS personnel to contact my HCP to authenticate or clarify information provided, if necessary. By signing below, I declare under penalty of perjury under laws of the state of Washington, the foregoing is true and correct and I meet all the requirements necessary for this application associated with State of Washington Proclamation 21-14.1.

Volunteer Signature	Date
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D HEALTH CARE PROVIDER COMPLETES SECTIONS D THROUGH F

The above noted volunteer has disclosed they have an underlying medical condition and/or disability, which may prevent them from receiving an authorized COVID-19 vaccine.

A complete application and medical certification is required to process a request for an Accommodation under the state of Washington August 20, 2021 [Proclamation 21-14.1](#) COVID-19 vaccination requirement for volunteers mandate. For a state agency covered by the proclamation to grant a reasonable accommodation to a volunteer to remain unvaccinated after October 18, 2021, the agency must receive supporting documentation from the volunteer’s health care provider. That documentation must confirm that the volunteer is medically unable to receive any of the available COVID-19 vaccines. The documentation must also include a duration the accommodation will be needed. Agencies cannot grant a medical accommodation to any volunteer to remain unvaccinated after October 18, 2021, if they have not received completed and supporting documentation.

We are requesting you complete the following form to help us to understand whether the volunteer has a medical condition, which prevents them from receiving an authorized COVID-19 vaccine.

Volunteer (Last, First, MI)

E HEALTH CARE PROVIDER STATEMENT

The above volunteer has reported they have an underlying medical condition and/or disability that prevents them from receiving an authorized COVID-19 vaccine. Does the volunteer suffer from such a condition?

Yes No

If Yes, please continue Section E. If No, please complete Section F - HEALTH CARE PROVIDER DECLARATION and return to WSU Extension.

DURATION OF NEED

In your medical opinion, what is the anticipated duration of the condition, which prevents the volunteer from receiving an authorized COVID-19 vaccination?

From ___/___/___ (mm/dd/yy) To ___/___/___ (mm/dd/yy) OR Other (Please describe below)

LEAVE OF ABSENCE

In your medical opinion, would a leave of absence be effective in allowing the volunteer 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

If Yes, in your medical opinion, what is the anticipated duration of leave required that would permit the volunteer to be able to receive an authorized COVID-19 vaccine?

From ___/___/___ (mm/dd/yy) To ___/___/___ (mm/dd/yy) OR Other (Please describe below)

F HEALTH CARE PROVIDER DECLARATION

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

HEALTH CARE PROVIDER NAME (Print or type)

HEALTH CARE PROVIDER SIGNATURE

DATE

HEALTH CARE PROVIDER ADDRESS

CITY, STATE ZIP

TYPE OF PRACTICE

TELEPHONE

FAX

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 do 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.