Central Washington University will provide reasonable accommodations to qualified applicants and employees with a medical condition or disability which prevents them from receiving an authorized COVID-19 vaccine, unless providing such accommodations would pose an undue hardship.

Proclamation 21-14.2 mandating a COVID-19 vaccine for state employee states:

> To the extent permitted by law, before providing a disability-related reasonable accommodation to the requirements of this order, individuals or entities for which Health Care Providers work as employees, contractors, or volunteers and State Agencies 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.

What this means:
For CWU, as an entity covered by the proclamation, to grant a reasonable accommodation to an employee to remain unvaccinated after October 18, 2021, the university must receive documentation from the employee's medical provider. That documentation must confirm that the employee is medically unable to receive any of the available COVID-19 vaccines. The documentation must also include a duration the accommodation will be needed. CWU cannot grant a disability-related accommodation to any employee to remain unvaccinated after October 18, 2021, if they have not received this documentation.

The main purpose of the specific COVID-19 questions is to enable the medical provider to verify whether the employee has a medical condition or disability which prevents them from receiving a COVID-19 vaccine.

If you have any questions, please do not hesitate to contact HR at 509-963-1202 or vaccine@cwu.edu. Please do not send or include any sensitive medical information if you contact us by email. We can discuss your questions and the method by which you can send your medical information to us, over the phone.

Request for Medical Accommodation
COVID-19 Vaccination Requirement

Authorization for Information (Employee Completes this Section)

Applicant/Employee Name:	____________________	Employee ID:	____________________
Employee Job Title:	____________________	Date of Birth:	____________________
Work Phone:	____________________	Work Email:	____________________
Name of Health Care Provider:	____________________	Provider Phone:	____________________

I hereby authorize the above-named health care provider to complete this form and disclose to Central Washington University and its authorized representatives the following information related to my health care: the diagnosis(es) of relevant conditions, treatment plan(s), my ability to perform my work, recommendations, history, reports, and correspondence.

I understand that it may be necessary for the university representatives to share this information for purposes related to accommodation of a disability. I authorize the university to share this information among appropriate staff and authorized representatives to the extent necessary to determine whether accommodation is necessary and to administer the accommodation process. My health record may include information related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV) behavioral or mental health services, and treatment for alcohol and drug abuse.

Once disclosed, the law does not always require the recipient of my information to maintain the confidentiality of my health care information. I understand that I have the following rights: a) to inspect or receive a copy of my protected health information, b) to receive a copy of this signed authorization, and c) to refuse to sign this authorization. I understand that information obtained under this release is a confidential medical record and is maintained separate from my personnel file. This authorization is valid for 90 days after the date of my signature below. However, I understand that I may revoke this consent, in writing, at any time except to the extent that action has already been taken based on the original authorization. I also understand that the above-named health care provider will not condition treatment or payment based on receipt of this signed authorization.

I hereby authorize my health care provider to discuss directly with a university representative any medical/mental health information relevant to my accommodation request. By signing this page, I acknowledge that I have read and agree to the terms described above. (NOTE to Employee: If you do not provide authorization for your health care provider to discuss the medical/mental health information relevant to your accommodation request, processing of your accommodation request may be delayed.)

Employee Signature: ______________________________ Date: ____________________

Forward this form to your health care provider!

COVID-19 Vaccination Medical Exemption Form

CWU employees: This form must be completed by a licensed health care provider (MD, DO, ND, ARNP, PA). The reviewing health care provider is required to be licensed in the state of Washington.

Health care provider: Please complete the form and return it to your patient who will then submit it to Central Washington University.

Patient Section

Patient Name____

Date of Birth________________________________ Employee ID _____________________________

CWU email____

Provider Review

The goal of Central Washington University is to vaccinate 100% of our employees and students against COVID-19. Vaccinations may not be appropriate for a small number of individuals (e.g. individuals with a history of severe reaction to a previous vaccine component). Guidance for medical exemptions for COVID-19 can be viewed on the CDC website. Please note, the following are NOT considered contraindications to COVID-19 vaccination:

1. Local injection site reactions after previous COVID-19 vaccines (erythema, induration, pruritus, pain)
2. Expected systemic vaccine side effects in previous COVID- 19 vaccines (fever, chills, fatigue, headache, lymphadenopathy, vomiting, diarrhea, myalgia, arthralgia)
3. Vasovagal reaction after receiving a dose of any vaccination
4. Being an immunocompromised individual or receiving immunosuppressive medications
5. Autoimmune conditions, including Guillain-Barre Syndrome
6. Allergic reactions to anything not contained in the COVID-19 vaccines, including injectable therapies, food, pets, venom, environmental allergens, oral medication, latex, etc.
7. Pregnancy or breastfeeding
8. Immunosuppressed person in the employee's household
9. Alpha-gal Syndrome
10. Allergy to egg or gelatin
11. Having a positive antibody titer

Select the medical contraindication(s) to COVID-19 vaccination below:

- ☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a component of a COVID- 19 vaccine. Please describe response in detail below and contraindication to alternatives in order for this request to be considered by the University.

This condition or circumstance is: temporary permanent

If temporary, provide the anticipated time range:________________________________

- ☐ Immediate allergic reaction to a previous dose or known (diagnosed) allergy to a component of the vaccine. Please describe response in detail below and contraindication to alternative vaccines.

This condition or circumstance is: temporary permanent

If temporary, provide the anticipated time range:________________________________

- ☐ Other medical circumstance preventing vaccination with any available COVID-19 vaccine. Please describe response in detail below and contraindication to alternative vaccines.

This condition or circumstance is: temporary permanent

If temporary, provide the anticipated time range:________________________________

- ☐ COVID-19 vaccination clinical trial participant. A licensed healthcare provider (MD, DO, ND, ARNP, PA) of the clinical trial team must sign this form as verification of enrollment.

Provider information and signature

Health Care Provider information (required for medical request):

Printed name: ____ Date: ___________________

Provider signature: ____

Select: ☐ MD ☐ DO ☐ ND ☐ ARNP ☐ PA

License #___________________ NPI #__________________________ State:__________________

Medical facility name: _______________________________________ Phone number:_____________

Address:____

Do not send this form to employee's supervisor. Send to CWU Human Resources:

Human Resources
Central Washington University
400 E. University Way
Ellensburg, WA 98926-7425

Email: ada@cwu.edu
FAX: 509-963-1733

If you have any questions, please do not hesitate to contact HR at 509-963-1202.