Bainbridge Island
Metro Park & Recreation District

MEDICAL EXEMPTION HEALTHCARE PROVIDER FORM

The Bainbridge Island Metro Park & Recreation District is committed to building an inclusive and welcoming work environment.

The District will provide reasonable accommodations to qualified applicants and employees with an underlying medical condition and/or disability, unless providing such accommodations would pose an undue hardship.

Employee Name: _____

Employee Job Title: _____

FOR THE HEALTHCARE PROVIDER

Dear Healthcare Provider,

Your patient is employed with the Bainbridge Island Metro Park & Recreation District and has disclosed they have a medical condition or disability which may prevent them from receiving an authorized COVID-19 vaccine.

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

> **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.B{b)(l)(i)(B).**

1. Are you licensed to practice in the State of Washington?

   ☐ YES ☐ NO

2. Describe your professional experience and/or educational background that qualify you to respond to questions about your patient's request for a medical exemption from the COVID-19 vaccination requirement.

   _____

   _____

   _____

   _____

3. Your patient has disclosed they have a medical condition or disability that may prevent them from receiving an authorized COVID-19 vaccine. Does your patient suffer from such a condition?
   ☐ YES ☐ NO

4. If you responded yes to question 3, what is the anticipated duration of the medical condition or disability which prevents your patient from receiving an authorized COVID-19 vaccination?
   ☐ Permanent ☐ Temporary

5. If temporary, provide a timeline indicating when we can expect your patient to be able to receive an authorized COVID-19 vaccination.

   _____

   _____

   _____

   _____

6. In your medical opinion, would a leave of absence be effective in allowing your patient to recover prior to receiving an authorized COVID-19 vaccine so they may return to the full duties of their position at the conclusion of the leave?
   ☐ YES ☐ NO

7. In your medical opinion, if a leave of absence is indicated, what is the anticipated duration of leave required that would permit your patient 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.

Physician Signature: _____ Date: _____

Printed Physician Name: _____

Please send your response via your patient. We would very much appreciate your response as soon as possible. District employees are required to be fully vaccinated with one of the authorized COVID-19 vaccines by December 20, 2021 or have an accommodation in place by December 13, 2021. To avoid delay, if agreeable to you and your patient, your responses may be emailed to terry@biparks.org. If you have any questions, please do not hesitate to contact us at the same email address. Employees may contact the Administrative Division Director with any questions.

REVIEW COMMITTEE:

Reviewed by: _____ Title: _____

Reviewed by: _____ Title: _____

Reviewed by: _____ Title: _____

Recommendation to: ☐ Approve ☐ Deny

Notes: _____

Date: _____

EXECUTIVE DIRECTOR'S FINAL REVIEW:

Name: _____ Signature: _____

☐ Approved ☐ Denied

Notes: _____

Date: _____