EMPLOYEE REQUEST FOR MEDICAL EXEMPTION FROM MANDATORY COVID-19 VACCINATION POLICY

Case Western Reserve University (CWRU) is committed to providing all employees with equal employment opportunities, and we recognize that employees with documented disabilities may need assistance or accommodations in order to achieve this objective. CWRU's Mandatory COVID-19 Vaccination Policy requires that, by July 23, 2021, all faculty, staff, and students whose work or study requires their presence on campus must establish that they are fully vaccinated, i.e., it has been two weeks since they have received their final dose of an approved COVID-19 vaccine. Please complete this form if you are seeking a medical exemption from CWRU's Mandatory COVID-19 Vaccination Policy.

To request an accommodation, 1) print and sign the first part of this form, 2) have the second part completed by your health care provider, and then 3) email the completed forms to equity@case.edu.

EMPLOYEE INFORMATION

FIRST NAME: MIDDLE INITIAL: LAST NAME:

DATE OF BIRTH:

CWRU ID Number:

POSITION: DEPARTMENT:

COLLEGE:

1. Identify the mental or physical impairment or other medical condition that does or may interfere with your ability to receive a COVID-19 vaccination.

2. My request for a medical exemption from CWRU's Mandatory COVID-19 Vaccination Policy is:

   ☐ Temporary, expiring on: ___/___/_____, or when _____.

   ☐ Permanent.

3. If CWRU provides you with a medical exemption from its Mandatory COVID-19 Vaccination Policy, CWRU will consider implementing additional safety procedures, including mask obligations, physical distancing, and testing requirements.

I acknowledge and agree that, if my request for an accommodation is granted, I would comply with such additional safety procedures as instructed by CWRU.

☐ YES ☐ NO

I verify that the information I am submitting to substantiate my request for a medical exemption from CWRU's Mandatory COVID-19 Vaccination Policy is true and accurate to the best of my knowledge. I understand that any falsified information can lead to disciplinary action, up to and including termination.

I further understand that CWRU is not required to provide this accommodation if doing so would pose a direct threat to myself or others in the workplace or would create an undue hardship for CWRU.

Employee Signature: _____

Date: _____

EMPLOYEE REQUEST FOR MEDICAL EXEMPTION FROM MANDATORY COVID-19 VACCINATION POLICY – MEDICAL PROVIDER CERTIFICATION

Employee Name: _____

Case Western Reserve University's (CWRU) Mandatory COVID-19 Vaccination Policy requires that, by July 23, 2021, all faculty, staff, and students whose work or study requires their presence on campus must establish that they are fully vaccinated, *i.e.*, it has been two weeks since they have received their final dose of an approved COVID-19 vaccine.

The individual named above requested a medical exemption from CWRU's Mandatory COVID-19 Vaccination Policy. Please review the below narrative and any other documents (including job description) attached prior to evaluating the individual named above, and then complete this form to assist CWRU in evaluating the individual's request for an accommodation. The information will be treated confidentially and only shared with only those who have a need to know. To the extent possible, please refrain from sharing any family medical history. We are only concerned with the named individual's own condition.[1]

STATEMENT OF EMPLOYEE:

I HEREBY AUTHORIZE MY MEDICAL PROVIDER TO RELEASE THE FOLLOWING MEDICAL INFORMATION TO CWRU FOR THE LIMITED PURPOSE OF ASSISTING CWRU TO FULFILL ITS DUTIES AND OBLIGATIONS UNDER THE AMERICANS WITH DISABILITIES ACT ("ADA") AND ANY STATE OR LOCAL DISABILITY LAWS.

Employee's Name (PLEASE PRINT): _____

_____ _____

Employee's Signature Date

[1] Similarly, the Genetic Nondiscrimination Act of 2008 (GINA) prohibits certain employers and other entities from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. Please do not provide any genetic 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.

CASE WESTERN RESERVE UNIVERSITY EST. 1826

TO: MEDICAL CARE PROVIDER

1. How long has this employee been under your care?

2. Is the employee currently under your care? Yes / No

3. Does the individual have a mental or physical impairment or other medical condition that does or may interfere with his or her ability to receive any one of the approved COVID-19 vaccinations?[2]

   YES _____ NO _____

If you answer NO, you may STOP, SIGN THE FORM, and return it to CWRU.

4. If you answered YES to Question 3, describe in detail the nature of the mental or physical impairment or other medical condition.

_____

_____

_____

5. Identify all approved COVID-19 vaccinations (*e.g.* Pfizer-BioNTech, Moderna, Johnson & Johnson's Janssen) that, in your medical opinion, the named individual should not receive due to the impairment or other medical condition identified in response to Question 4 above.

_____

_____

_____

[2] We do not need you to respond with any information about any condition that has absolutely no bearing on the ability of the individual to receive one of the COVID-19 vaccinations. You may answer "No" to this question if they have a condition, but in your medical opinion, it has no limitations or restrictions that would in any way interfere with the ability of the named individual to receive one of the COVID-19 vaccinations.

6. Explain how the impairment or medical condition above does or may interfere with the named individual's ability to receive the COVID-19 vaccination(s) you identified in response to Question 5 above.

_____

_____

_____

7. How long is the mental or physical impairment or other medical condition identified in response to Question 4 likely to last?

   The impairment/condition commenced on: _____

   The impairment/condition is likely to last until: _____

   Further comments:

_____

_____

8. The requested exemption from CWRU's Mandatory COVID-19 Vaccination Policy should be:

   ☐ Temporary, expiring on: ___/___/_____, or when _____.

   ☐ Permanent.

9. To the extent that CWRU could potentially provide the named individual with a medical exemption from CWRU's Mandatory COVID-19 Vaccination Policy, CWRU may implement additional safety procedures, including mask obligations, physical distancing, and testing requirements. Could the named individual safely comply with these additional procedures?

   YES _____ NO _____

   If no, please explain which additional safety procedures the named individual could not safely comply with and a detailed explanation as to why.

_____

_____

10. Please provide any additional information you believe would be helpful to CWRU in evaluating the named individual's request for a medical exemption from CWRU's Mandatory COVID-19 Vaccination Policy.

_____

_____

_____

I certify the above information to be true and accurate, and request exemption from the COVID-19 vaccination(s) identified above for the individual named above.

Physician Contact information:

Address: Telephone:
FAX and/or Email address:

Printed Name: **Professional Signature:**
License #: **Date:**

Thank you for taking the time to complete this form. If we need additional information, we may contact you at a later date. Please return a completed copy of this form to the Office for Equity at 216-368-8805, or at equity@case.edu.