**INSTRUCTIONS TO THE HEALTHCARE PROVIDER:**

Company Name is requiring that its employees be vaccinated against COVID-19.

**Your patient has requested, as a reasonable accommodation, to be exempted from the Company’s COVID-19 vaccination mandate for medical reasons.**

Please complete this form to assist us in evaluating your patient’s request.

**Please note that as part of this process, we are ONLY seeking confirmation of your patient’s medical inability to be vaccinated, and the duration of such, if applicable.**

**Do not provide any information identifying your patient’s medical condition, diagnosis, or treatment. We are not requesting, nor can we receive, such information.**

The authorities that allow us to request and receive the information being requested in the attached questionnaire are the two following California laws:

* **California Confidentiality of Medical Information Act** (California Civil Code Section 56.10.8(b)): The Company can receive information from a Health Care Provider that:

– “(B) Describes functional limitations of the patient that may entitle the patient to leave from work for medical reasons or limit the patient’s fitness to perform his or her present employment, provided that no statement of medical cause is included in the information disclosed.”

* **California Code of Regulations** (CCR) (tit 2 § 11069(d)) provides that:

– “The applicant or employee shall cooperate in good faith with the employer…, including providing reasonable medical documentation where the disability or the need for accommodation is not obvious and is requested by the employer…”

***IMPORTANT***

***Do not identify the patient’s diagnosis, disability, or other medical information (other than COVID-19 diagnosis in Part B) as this document will be returned to the Company Name.***

# SECTION A: To be completed by Employee

|  |  |
| --- | --- |
| **EMPLOYEE NAME** | **EMPLOYEE ID** |
| **JOB TITLE** | **DEPARTMENT** |

# SECTION B: To be completed by the Healthcare Provider

I have reviewed the **Instructions to this Healthcare Provider Statement** for the above-named patient and can provide the following certification:

***(Check boxes and insert text as appropriate)***

1. Is your patient medically restricted from receiving the COVID-19 vaccine?

** NO**, my patient is not medically restricted from receiving the COVID-19 vaccine. (Please skip to the end of this questionnaire and sign and date.)

** YES**, my patient is medically restricted from receiving the COVID-19 vaccine. Please explain:

a. What is the duration of the restriction from receiving a COVID-19 vaccine?

** PERMANENT**, it is not medically expected that my patient will ever be able to receive a COVID-19 vaccine.

** TEMPORARY**, it is anticipated that my patient will be cleared to receive a COVID-19 vaccine on or about \_\_\_\_\_\_\_\_\_\_\_\_\_ (date).

** UNKNOWN**. I am unable to comment on my patient’s ability to receive a COVID-19 vaccine in the future.

|  |  |
| --- | --- |
| **HEALTH CARE PROVIDER NAME** | **HEALTH CARE PROVIDER PHONE/EMAIL** |
| **LICENSE TYPE, # AND ISSUING STATE** | **PHYSICIAN SUPERVISOR NAME AND LICENSE #**  **FOR A PHYSICIAN ASSISTANT WORKING UNDER A PHYSICIAN’S LICENSE)** |

|  |  |
| --- | --- |
| **HEALTHCARE PROVIDER SIGNATURE & DATE** |  |

**FOR COMPANY USE ONLY: FORM RECEIVED ON \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, BY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**