COUNTY OF LAKE ADDENDUM XIIIa
MEDICAL EXEMPTION AND/OR DISABILITY EXCEPTION REQUEST FORM
Exception to SARS-CoV-2 (COVID-19) Vaccination Requirement

Full Name	Job Title
Department	**Location of Worksite**
Supervisor	**Email**
Phone Number	**Cell Number**

This form should be used by County of Lake employees, contractors, interns, and volunteers working or volunteering on- site at a County facility or other County location that is required to have a COVID-19 vaccination per the California State Public Health Officer Order, to request an exception to the County's COVID-19 vaccination requirement based on:

A. ***Medical exemption due to a contraindication or precaution to COVID-19 vaccination recognized by the U.S. Centers for Disease Control and Prevention (CDC) or by the vaccines' manufacturers.***
B. ***Disability.***

Fill out Part A to request an Exception based on Medical Exemption. Fill out Part B to request an Exception based on Disability. Both sections may be completed if both apply to you, and both sections refer to an attached certification form from a qualified licensed health care provider.

Important: Do not identify any diagnosis, disability, or other medical information. That information is not required to submit your request.

Part A: Request for Exception Based on Medical Exemption

☐ The Contraindications or Precautions to COVID-19 vaccination recognized by the CDC or by the vaccines' manufacturers apply to me with respect to all available COVID-19 vaccines. For that reason, I am requesting an Exception to the COVID-19 vaccination requirement based on medical exemption. My request is supported by the attached certification from my physician, nurse practitioner, or other licensed medical professional practicing under the license of a physician.

Part B: Request for Exception Based on Disability

☐ I have a Disability and am requesting an Exception to the COVID-19 vaccination requirement as a disability accommodation. My request is supported by the attached certification from my licensed physician, nurse practitioner, or other licensed medical professional practicing under the license of a physician.

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Please provide any additional information that you think may be helpful in processing your request. ***Again, do <u>not</u> identify your diagnosis, disability, or other medical information.***

While my request is pending, I understand that I must comply with all other COVID-19 prevention requirements (e.g., face coverings, regular asymptomatic testing) for unvaccinated or not fully vaccinated individuals under County policy and state and local public health directives. If my request is granted, I understand that I will be required to comply with COVID-19 prevention requirements, other than vaccination, as specified.

I verify the truth and accuracy of the statements in this request form.

Signature:_____ Date:_____

Please send this completed form to the County of Lake Human Resources Department.
Address: 255 North Forbes Street, Room 112
Lakeport, CA 95453
Phone: 707-263-2213
Confidential Fax: 707-262-1843
Confidential HR Email: HR@lakecountyca.gov

Name of County Staff Receiving This Request Form: _____

Date Received:_____

CERTIFICATION FROM PHYSICIAN, NURSE PRACTITIONER, OR OTHER LICENSED MEDICAL PROFESSIONAL PRACTICING UNDER THE LICENSE OF A PHYSICIAN

The County of Lake requires that its employees, contractors, interns, and volunteers working or volunteering on-site at a County facility or other County location that is required to have a COVID-19 vaccination per the California State Public Health Officer Order to be vaccinated against COVID-19 infection.

The County may grant exceptions to this requirement based on:

A. Medical exemption due to a contraindication or precaution to COVID-19 vaccination recognized by the U.S. Centers for Disease Control and Prevention (CDC) or by the vaccines' manufacturers

B. Disability, provided that the individual's request for such an exception is supported by a certification from their qualified licensed healthcare provider.

Full Name of Patient	Date of Birth of Patient
Health Care Provider Name	**Health Care Provider License Type and Number**
Health Care Provider Issuing State	**Health Care Provider Phone Number**
Health Care Provider Fax Number	**Health Care Provider Email**
Physician Supervisor And License # (For A Physician Assistant Working Under A Physician's License)	

Please complete Part A of this form if one or more of the contraindications or precautions to COVID-19 vaccination recognized by the CDC or the vaccines' manufacturers apply to this patient with respect to* all *FDA-authorized COVID-19 vaccines.

Please complete Part B if this patient has a disability, as defined below, that makes COVID-19 vaccination inadvisable in your professional medical opinion. Both sections may be completed if both apply to this patient. <u>Important</u>: Do not identify the patient's diagnosis, disability, genetic information, [1] or other medical information as this document will be returned to the County of Lake, which employs, contracts with, or otherwise works with patient.

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[1] Per the Genetic Information Nondiscrimination Act of 2008 (GINA), "genetic information" 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.

CERTIFICATION FROM PHYSICIAN, NURSE PRACTITIONER, OR OTHER LICENSED MEDICAL PROFESSIONAL PRACTICING UNDER THE LICENSE OF A PHYSICIAN

Exception to SARS-CoV-2 (COVID-19) Vaccination Requirement

Part A: Contraindication or Precaution to COVID-19 Vaccination

☐ I certify that _____ is my patient, and that one or more of the contraindications or precautions recognized by the CDC or by the vaccines' manufacturers for each of the currently available COVID-19 vaccines applies to the patient listed above. For that reason, COVID-19 vaccination using *any* of the currently available COVID-19 vaccines is inadvisable for this patient in my professional opinion. The contraindication(s) and/or precaution(s) is/are:
☐ Permanent ☐ Temporary.

If temporary, the expected end date is: _____

Part B: Disability That Makes COVID-19 Vaccination Medically Inadvisable

"Disability" is defined as a physical or mental disorder or condition that limits a major life activity and any other condition recognized as a disability under applicable law. "Disability" includes pregnancy, childbirth, or a related medical condition where your medical opinion is that COVID-19 vaccination is inadvisable.

☐ I certify that _____ is my patient and has a disability, as defined above, that makes COVID-19 vaccination medically inadvisable in my professional opinion. The patient's disability is:
☐ Permanent ☐ Temporary.

If temporary, the expected end date is: _____

_____ _____
Signature of Health Care Provider Date

Please give this completed form directly to your patient or send it to the County of Lake Human Resources Department.
Address: 255 North Forbes Street, Room 112
Lakeport, CA 95453
Phone: 707-263-2213
Confidential Fax: 707-262-1843
Confidential HR Email: HR@lakecountyca.gov