MEDICAL ACCOMMODATION REQUEST FORM
COVID-19 REQUIRED VACCINATION POLICY (BP/AP 7330)

To request a medical exemption from the required COVID-19 vaccination, please complete Section 1 below and have your medical provider complete Section 2 before returning to Human Resources. Please be advised that you will need to give a copy of your Job / Position Description to your medical provider with this form. Job / Position Descriptions can be found on the HR webpage (miracosta.edu/hr)

Section 1 – Employee Completes

Name:		Employee ID:	
Phone:		Email:	
Job Title:		Dept:	
Supervisor:			

I verify that the information I am submitting to substantiate my request for exemption from MiraCosta Community College 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 the District is not required to provide an exemption accommodation if doing so would pose a direct threat to myself or others in the workplace or would create an undue hardship for the college.

Employee Signature:		Date:	

Section 2 - Licensed Medical Provider Completes

Dear Medical Provider,

MiraCosta College requires all employees to be fully vaccinated against COVID-19 as a condition of employment. The employee listed above is seeking an exemption to the District's mandatory COVID-19 vaccination policy due to a disability or serious medical condition. Please complete this form to assist the College in the disability accommodation process. Should you have any questions, please contact Human Resources at 760-795-6855 or hr_department@miracosta.edu.

(Check boxes and insert text as appropriate)

1. Does your patient have a medical and/or psychological impairment that limits their ability to engage in a major life activity, such as the ability to work, care for themselves, perform manual tasks, walk, see, hear, eat, sleep, or engage in social activities.

   ☐ NO, my patient does not have a physical or mental impairment that limits their ability to engage in a major life activity.

   ☐ YES, my patient has a ☐ PHYSICAL and/or ☐ MENTAL impairment that limits their ability to engage in a major life activity.

2. If the answer to question number one is yes, does the impairment currently affect your patient's ability to perform the essential functions their position as described in the Job / Position Description provided?

   ☐ NO, my patient's impairment does not limit their ability to perform all of the essential functions of their position as defined in the Job / Position Description provided.

   ☐ YES, my patient's impairment does affect their ability to perform **one or more** of the essential functions of their position as defined in the Job / Position Description provided.

3. **CURRENT WORK ENVIRONMENT:** MiraCosta Community College has implemented the following protocols which meet or exceed OSHA and CDC guidelines for workplace safety:

   - A mandatory vaccination policy for employees. Employees with an approved exemption for medical or religious reasons must be tested weekly for COVID-19 when the CDC Community Risk Level is medium or high;
   - Providing clean, undamaged face coverings to all employees, students, and visitors to campus;
   - Providing respirators upon request to employees and students, including proper training in the use of a respirator;
   - Increased cleaning and disinfection measures for frequently touched surfaces or shared workspaces by custodial staff;
   - Provision of disinfectants and cleaning supplies to employees to disinfect their workspaces in between regular cleaning schedules;
   - Increased hand-sanitizing procedures. This includes providing effective hand sanitizers throughout campus and in all shared workspaces; encouraging and allowing employees time for increased handwashing; encouraging employees, students, and visitors to wash hands for at least 20 seconds each time through increased signage and marketing campaigns; and regular monitoring and evaluation of campus facilities for supplies;
   - Maximizing the quantity of outdoor air in employee work spaces, and increasing filtration efficiency to the highest level compatible with campus buildings and existing ventilation systems. All District-owned buildings have been upgraded to MERV13+ filtration levels;
   - Requiring employees and students with a COVID-19 exposure to test 3 to 5 days after exposure;
   - Providing COVID-19 testing at no cost to all employees or students who had potential close contact COVID-19 exposure;
   - Prohibiting the use of shared PPE, e.g., gloves, goggles, and face shields;
   - Requiring periodic inspections of District worksites and facilities as needed to identify unhealthy conditions, work practices, and work procedures related to COVID-19 and to ensure compliance with the District's COVID-19 policies and procedures.
   - Other (e.g., patient has their own office) _____

Employee Name: _____

The above list of safety measures have been taken to protect your patient and their colleagues as their work has been deemed mission critical/essential to the business. Are the above measures sufficient to support your patient to return to the workplace:

☐ YES, the above measures are sufficient to support my patient to return to the workplace.

☐ NO, the above measures are insufficient to support my patient to safely return to the workplace. The following safety precautions also need to be implemented if my patient is to return to work in the physical workplace: (please be specific):

_____

_____

_____

_____

_____

☐ NO, there are no workplace accommodations or modifications that can be made that will support me to release my patient to in-person work at this time.

☐ OTHER / ADDITIONAL INFORMATION: _____

_____

_____

_____

4. **VACCINATION CLARIFICATION**:

   a. Is your patient medically expected to be eligible to receive a COVID-19 vaccine?

☐ NO, my patient is medically restricted from being administered a COVID-19 vaccination due to their personal medical condition.

☐ YES, my patient is medically ABLE to receive a COVID-19 vaccination.

☐ OTHER: _____

_____

_____

_____

b. If you have RESTRICTED your patient from being in the workplace at this time, and if you have indicated above that your patient IS medically able to be administered a COVID-19 vaccine, will any restrictions listed above end 2 weeks after their final dose?

☐ YES, 2 weeks after my patient has their final dose of vaccine, my patient will have no work restrictions. They will not require additional limitations.

☐ NO, even after receiving the vaccines, my patient's work restrictions will remain in place. The vaccine does not change their COVID-related accommodation needs.

☐ OTHER / ADDITIONAL INFORMATION: _____

_____

_____

_____

5. If you have answered NO to the question above and that your patient's restrictions will remain in place even after they are vaccinated, please clarify how long the District would need to expect your patient to be restricted.

☐ **PERMANENTLY**

☐ **TEMPORARILY THROUGH _____ (DATE),** on or about this date it would be expected they will be medically released to return to work.

☐ **UNKNOWN**, **Please clarify:** _____

_____

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_____

6. **ESSENTIAL FUNCTIONS / JOB DESCRIPTION REVIEW:** In reviewing the attached Job / Position Description are there any unmodified job activities listed that you would restrict your patient from doing, either partially or wholly, in addition to what is listed above?

☐ NO, my patient is unrestricted in the performance of any additional physical, mental and emotional demands listed in the attached Job / Position Description, other than what is listed above.

☐ YES, my patient has the following additional work restrictions / functional limitations:

Employee Name: _____

a. Page_____ Activity: _____

_____

_____

Limitation: (clarify what patient is able to do for each restricted activity) _____

_____

_____

_____

b. Page_____ Activity: _____

_____

_____

Limitation: (clarify what patient is able to do for each restricted activity) _____

_____

_____

_____

c. Page_____ Activity: _____

_____

_____

Limitation: (clarify what patient is able to do for each restricted activity) _____

_____

_____

_____

d. Page_____ Activity: _____

_____

_____

Limitation: (clarify what patient is able to do for each restricted activity) _____

_____

_____

_____

Employee Name: _____

7. **DURATION OF RESTRICTIONS:** Please confirm the duration of the restrictions in paragraph 6 by checking the appropriate box below:

   ☐ Accommodation Needs / Restrictions are **TEMPORARY through _____ (DATE)**

   ☐ Accommodation Needs / Restrictions are **PERMANENT**

   ☐ Accommodation Needs / Restrictions are for and **UNKNOWN** duration

   ☐ **OTHER / ADDITIONAL INFORMATION**: _____

   _____

   _____

8. **Additional Restrictions / Accommodation Suggestions**: Please use the space below to include any additional information that you believe would be helpful to the interactive process for this employee. You may attach additional pages as needed. **Please do not list any information pertaining to medical condition or diagnosis.**

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   _____

   _____

   _____

   _____

   _____

   _____

   _____

_____ _____
Health Care Provider's Original Signature Date

_____ _____
Health Care Provider's Name Printed License Number

PLEASE RETURN A COPY OF THIS FORM VIA FAX OR SECURE MAIL TO:
Hayley Schwartzkopf, Director of Labor Relations
Fax: 760.795.6867
Secure Email: hschwartzkopf@miracosta.edu
Questions: 760.795.6672