



MEDICAL EXEMPTION REQUEST FORM PROCLAMATION 21-14 (VACCINE REQUIREMENT)

Renton Technical College will provide reasonable accommodations to qualified applicants and employees with a medical condition or disability which prevents them from receiving an authorized COVID-19 vaccine, unless providing such accommodations would pose an undue hardship.

Instructions for employees:

Below are initial intake questions for you to respond to in requesting a medical exemption pursuant to Proclamation 21-14 exemption.

Please return this form and your response to [Sally Allen](#) or [Lesley Hogan](#) (Renton Technical College Human Resources 3000 NE 4th St. Renton, WA 98056). **Please complete your response as soon as possible to help us assure timelines for response can be met.** To avoid delay, please feel free to electronically transmit your response to the following fax number: **425-235-2567** or through secure email transmittal. If you have any questions or need more information, please do not hesitate to contact [Sally Allen](#) at **425-235-7874**, or [Lesley Hogan](#) at **425-235-7873**.

Employee name and Employee Number: _____.

You, _____ [employee name], assert that you have a medical condition or disability that prevents you from receiving the COVID-19 vaccine.

YES NO

If you checked “YES”, please complete the attached Waiver and Authorization to Release Information. This will allow Sally Allen or Lesley Hogan to directly contact your physician to confirm they are licensed to practice in the state of Washington and confirm that you have a medical condition or disability that prevents you from receiving the COVID-19 vaccine. Please also answer the questions below to assist us in our reasonable accommodation assessment.

1. What is the specific accommodation you are requesting?



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Waiver and Authorization to Release Medical Information

I [employee name] have requested a medical exemption for the COVID-19 vaccine requirement from my employer, Renton Technical College (RTC).

I hereby authorize Sally Allen, Assistant Director of Human Resources and/or Lesley Hogan, Executive Vice President of Human Resources to receive medical information that will allow my employer to evaluate whether I have a medical condition or disability preventing me from receiving an authorized COVID-19 vaccine. If this information includes medical information related to mental health issues, alcohol, or drug treatment, or sexually transmitted diseases, I specifically authorize the release of that information as indicated below (please check all that apply, if any):

- Mental Health Records (RCW 71.05)
Alcoholism, Intoxication, and Drug Addiction (RCW 70.96A)
Sexually Transmitted Diseases and HIV/AIDS (RCW 70.24)

I give permission for the use and disclosure of my confidential medical information solely on a need to know basis and solely for this stated purpose.

I understand that I may revoke or discontinue my authorization in writing at any time, and that revocation will not affect any information already shared.

A photocopy and/or fax of this release form will be valid as an original, even though the said photocopy and/or fax does not contain an original writing of my signature.

This authorization is valid for ninety (90) days from the date of signature unless specifically revoked during this time.

Employee's Name (Please Print)

Employee's Signature

Date

Please indicate the name, address, phone, and fax number of the health care professional you consulted with who has the expertise to give an opinion about the specific diagnosis and the limitations imposed by it, and to whom we may send a Medical Questionnaire.

Name of Health Care Professional

Area of Expertise

Address

Phone Number

Fax Number