

## REQUEST FOR MEDICAL EXEMPTION COVID-19 VACCINE

The Northwest Indian College COVID-19 Vaccination Policy 809 requires all employees and students to be fully vaccinated. In addition, the Lummi Nation COVID-19 Vaccination Mandate requires all employees of the Lummi Indian Business Council and its entities to be fully vaccinated.

A medical exemption may be granted if (i) the individual is medically unable to be vaccinated against COVID-19, (ii) completes this form, and (iii) provides documentation to support the exemption request.

In accordance to the Lummi Nation Mandate, all medical exemptions must be requested by October 18, 2021, and if approved, the exemption will remain in effect through December 31, 2022.

Individuals with approved exemptions may request to recertify exemptions each year thereafter. The assigned expiration is at the sole determination of LIBC and may be altered or amended. The Human Resources (HR) Department will notify employees if LIBC alters or amends the expiration date. Decisions are final and not subject to appeal. Individuals whose requests have been denied are permitted to reapply if new documentation and information becomes available.

**Note:** Requesting an exemption does not equate to registration as an individual with a disability. If you require a disability-related accommodation outside of this exemption, please contact the HR Department and review the NWIC HR Personnel Policy Manual Section 12.7 Employee Disability.

To qualify for the medical exemption, you are required to have your primary health care provider certify that you should not be vaccinated for COVID-19 by completing Section 2 of this form.

CDC Approved Medical Exemptions for COVID-19 include:

- (1) Immunocompromised
- (2) Guillain-Barre Syndrome (GBS)
- (3) Bell's Palsy
- (4) Known allergies to vaccine ingredients
  1. CDC Guidelines for COVID-19 Vaccines for People with Underlying Medical Conditions. Accessed on August 27, 2021 at <https://www.cdc.gov/coronavirus/2019-ncov/vaccines/recommendations/underlying-conditions.html>

**Section 1: Employee Certification**

I understand that NWIC and LIBC require COVID-19 vaccination as a condition of employment as outlined within NWIC Employment Contracts and within the NWIC HR Personnel Policy Manual, Section 14 Work Environment.

I hereby certify that I believe that I have a medical condition that necessitates an exemption from this vaccination requirement. I also understand that individuals with an approved exemption may be required to comply with additional testing and other preventative requirements.

I certify that the information I am submitting in support of my request for an accommodation is complete and accurate to the best of my knowledge and I understand that any misrepresentation contained in this request may result in revocation of the exemption and disciplinary action.

I understand that my request for an accommodation may not be granted if it is not reasonable, if it poses a direct threat to the health and/or safety of others and/or to me, or if it creates an undue hardship on NWIC. I also understand that, if approved, this exemption is provisional based on the current Lummi Nation COVID-19 Vaccination Mandate and is subject to change based on Lummi Nation vaccination requirements moving forward. I understand that, if approved, I must follow the COVID-19 travel policies and that I must wear an N95 mask while at work and comply with NWIC Campus Safe Operations Procedure 603.

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Name of Employee (Print)

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Signature Date

**Section 2: Provider Certification**

A licensed physician, physician assistant (PA), or nurse practitioner (NP) must complete this section. Forms completed by the employee for this section will not be accepted.

**Physician/Provider Instructions:** By completing this form, you certify that different methods of vaccinating against COVID-19 have been considered, and that the following medical contraindication precludes any/all vaccinations for COVID-19.

1. **Allergy:** Does the patient have a documented history of a severe allergic reaction to any component of a COVID-19 vaccine or to a substance that is cross-reactive with a component of a COVID-19 vaccine?

\_\_\_\_\_ YES      \_\_\_\_\_ NO

Please indicate which of the following vaccines are contraindicated. If possible, list the components.

- Moderna – list the component(s): \_\_\_\_\_
- Pfizer – list the component(s): \_\_\_\_\_
- Johnson & Johnson – list the component(s): \_\_\_\_\_

Does the patient have a documented history of a severe allergic reaction after a previous dose of the COVID-19 vaccine?

\_\_\_\_\_ YES      \_\_\_\_\_ NO

Please indicate which vaccine the patient had a reaction to

- Moderna date of vaccine and reaction: \_\_\_\_\_
- Pfizer date of vaccine and reaction: \_\_\_\_\_
- Johnson & Johnson date of vaccine and reaction: \_\_\_\_\_

2. **Physical condition/Medical circumstance:** In accordance with the CDC approved medical exemptions for COVID-19, does the patient have another physical condition or medical circumstance preventing vaccination with any available COVID-19 vaccine.

\_\_\_\_\_ YES      \_\_\_\_\_ NO

Please state, with sufficient detail for independent medical review, the specific nature and probable duration of the condition or circumstances that may prohibit the patient from receiving the COVID-19 vaccine (attach additional pages if necessary).

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**Medical Certification:** I certify that \_\_\_\_\_ (patient name) has the above contraindication and support the request for a medical exemption from the COVID-19 vaccine requirement.

\_\_\_\_\_  
Name of Medical Provider (Print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Medical Provider

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**To be completed by a Human Resources (HR) employee and Supervisor of employee:**

Date request received: \_\_\_\_\_

Exemption/Accommodation approved: \_\_\_\_\_ YES \_\_\_\_\_ NO

Name of HR employee: \_\_\_\_\_

Signature of HR employee: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Supervisor of employee: \_\_\_\_\_

Signature of Supervisor of employee: \_\_\_\_\_ Date: \_\_\_\_\_