QUESTIONNAIRE FOR MEDICAL PROVIDER

MEDICAL PROVIDER NAME: _____

MEDICAL PROVIDER PHONE NUMBER: _____

MEDICAL PROVIDER ADDRESS: _____

MEDICAL PROVIDER LICENSE NUMBER: _____

EMPLOYEE NAME: _____

To Medical Provider: The Gavilan Joint Community College District requires employees to be fully vaccinated against COVID-19. This form is to certify whether the District employee named above has:

- a contraindication or precaution to COVID-19 vaccination recognized by the Centers for Disease Control and Prevention ("CDC") or by the vaccines' manufacturers; ***or***
- a COVID-19-related diagnosis or treatment within the last 90 days recognized by the CDC as a contraindication or precaution to the available COVID-19 vaccinations; ***or***
- a disability within the meaning of the Fair Employment and Housing Act ("FEHA") and the Americans with Disabilities Act ("ADA") that limits the employee's ability to be fully vaccinated against COVID-19.

Please only answer the specific questions asked below and do not provide any additional information. Do not provide any information regarding diagnosis, medical cause, or medical history. Your responses should be limited to your determination of the employee's limitations or need for accommodations, if any. Further, the Genetic Information Nondiscrimination Act of 2008 ("GINA") prohibits employers from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. Therefore, we also request that you not provide genetic information when responding to this request.

Section A: Disability Related Questions

1. Does the employee have an underlying medical condition that limits the employee from being fully vaccinated against COVID-19 using any of the currently available COVID-19 vaccines? DO NOT SPECIFY THE CONDITION.

   Yes ☐ No ☐

2. If your answer to question one is "Yes," is the medical condition a physical or mental impairment that limits the employee's 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? A condition can be said to "limit," if the condition makes the achievement of the major life activity more difficult.

Yes ☐ No ☐

Probable Duration of the Medical Condition: _____

Section B: Health or Medical Condition Related Questions

1. Does the employee have a contraindication or precaution to COVID-19 vaccination recognized by the Centers for Disease Control and Prevention ("CDC") or by the vaccines' manufacturers?

   Yes ☐ No ☐

   Probable Duration of the Contraindication or Precaution: _____

2. Did the employee receive a COVID-19-related diagnosis or treatment within the last 90 days that is recognized by the CDC as a contraindication or precaution to the available COVID-19 vaccinations?

   Yes ☐ No ☐

   Probable Duration of the Contraindication or Precaution: _____

_____ _____

Medical Provider Signature Date