Franklin Pierce Schools
Human Resources
315 129th Street S, Tacoma, WA 98444
253-298-3085, Fax 253-298-3016
www.fpschools.org

COVID Accommodation From

Instructions:

1. Read and sign the Authorization for Release of Medical Information

2. Take the packet to your Dr. and ask him/her to complete the packet and return it as soon as possible.

3. Return the packet directly to:
   Brandy Marshall
   Director of Human Resources
   315 129th ST S
   Tacoma, WA 98444
   or
   FAX: (253)298-3016
   or
   deliver to the mail slot to the left of the HR door at the district office in an envelope addressed to Brandy Marshall.

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____ (employee name), authorize _____ (physician name) to release all medical information pertinent to the attached document, including diagnoses, treatment plans, reports, and recommendations, to the Franklin Pierce School District and its authorized representatives.

The information identified above will be used by the persons to whom it is disclosed for consultation for the purpose of determining whether there are any physical limitations that prevent me from performing all of my assigned job duties, whether I am disabled within the meaning of the Americans with Disabilities Act, and if so, whether there are any reasonable accommodations that would enable me to perform the job.

This permission expires ninety (90) days after the date it is signed. I can cancel this authorization at any time, but I understand that the cancellation will not affect any information that was already released before the cancellation. I understand that if the medical information described above is not released, my request for reasonable accommodation may be delayed.

I understand that this information is confidential, is protected by state and federal law and requires my consent before disclosure. I understand that it may be necessary for school representatives to share this information among appropriate staff and authorized representatives to determine whether accommodation is necessary and to administer the accommodation process. I voluntarily approve the release of this information. I understand what this agreement means.

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV/AIDS, sexually transmitted diseases, psychiatric disorder/mental health, or drug and/or alcohol use.

_____ _____

Signature Date

_____

Printed Name

To those receiving information under this authorization. The information disclosed to you under this authorization is protected by state and federal law. You are not authorized to release it to any agency or person not listed on this form without specific written consent of the person to whom it pertains. A general authorization for release of medical or other information is not sufficient. Ch. 70.02.RCW.

Medical Inquiry Form in response to a COVID-19 related accommodation request

A. Questions to help determine whether an employee has a condition that meets the Center for Disease Control's (CDC) definition of being at high risk for COVID-19.

The CDC lists the following conditions to be at increased risk of severe illness from the virus that causes COVID-19:

- Cancer
- Chronic kidney disease
- COPD (chronic obstructive pulmonary disease)
- Down Syndrome
- Heart conditions
- Immunocompromised state (solid organ transplant)
- Obesity (body mass index of 30-40 kg/m^2)
- Severe Obesity (body mass index of 40 kg/m^2 or greater)
- Pregnancy
- Sickle cell disease
- Type 2 diabetes mellitus

Does the employee have one of these conditions? Yes ☐ No ☐

If yes, what is the condition?

B. Questions to help determine whether an employee has a condition that meets the CDC's definition that might be at an increased risk for COVID-19.

The CDC lists the following conditions to be at increased risk of severe illness from the virus that causes COVID-19:

- Asthma (moderate to severe)
- Cerebrovascular disease
- Cystic fibrosis
- Hypertension or high blood pressure
- Immunocompromised state (blood or bone marrow transplant, immune deficiencies, HIV, use of corticosteroids, etc.)
- Neurologic conditions
- Liver disease
- Overweight (BMI >25-29 kg/m^2)
- Pulmonary fibrosis
- Thalassemia
- Type 1 diabetes mellitus

Does the employee have one of these conditions? Yes ☐ No ☐

If yes, what is the condition? Does the condition place the employee at a higher risk for COVID-19? If yes, please explain why.

C. Questions to help determine what type of supports are needed to mitigate COVID-19 risks.*

The following questions may help us determine whether we can create a workspace or assignment that will effectively mitigate the increased risk presented by the condition identified on this form.

What aspect of the employee's job responsibilities or workspace cause the employee to be at increased risk from COVID-19?

What precautions could be implemented to decrease this risk and allow the employee to safely perform all job responsibilities in their regular workspace?

What conditions would need to be established for the employee to return to their regular job responsibilities and workspace without precautions?

What other factors should be considered as we problem solve ways to keep this employee as safe as possible while performing their job responsibilities?

_____ _____

Medical Professional's Signature Date

_____ _____

Medical Professional's Printed Name Primary Contact Information

*Responding to these questions is optional but encouraged so the District can fully explore options for accommodation.