KANSAS STATE UNIVERSITY

Covid-19 Vaccine Medical Exemption Request

Mandatory COVID-Vaccine Policy

Kansas State University requires all employees to be fully vaccinated against COVID-19. This form should be used by employees who are requesting an exemption from the mandatory vaccine requirement due to a medical condition that prevents them from getting the COVID-19 vaccine. While waiting for an exemption decision, employees must continue to follow university guidance on face coverings on campus and follow other safety measures.

Section I: To be completed by employee

Last Name _____First Name_____ Middle Initial _____
Email _____ Phone Number_____
Supervisor's Name_____

I am requesting a medical exemption to the requirement for COVID-19 vaccination or a delay because of a temporary condition or medical circumstance. I understand the content of the Medical Exemption Request form and the University's COVID-19 vaccine requirement and affirm that the information I have provided is true and correct to the best of my knowledge and ability.

Employee Signature: _____ Date: _____

Section II: Medical Exemption Request (to be completed by medical provider)

Kansas State University requires its employees to be fully vaccinated against COVID-19 pursuant to requirements for federal contractors. The individual named above is seeking a medical exception to the requirement for COVID-19 vaccination or a delay of vaccination because of a medical condition, either temporary or permanent. Please complete this form to assist Kansas State University in its medical exemption process.

Is this request permanent or temporary? ☐ Permanent ☐ Temporary

If the exemption is temporary, please indicate the proposed time frame for the exemption.

_____

Please provide the following information and add additional pages as needed.

1. Explain the applicable contraindication or precaution for COVID-19 vaccination, and for each contraindication or precaution, indicate: (a) whether it is recognized by the CDC pursuant to its guidance; and (b) whether it is listed in the package insert or Emergency Use Authorization fact sheet for each of the COVID-19 vaccines authorized or approved for use in the United States.

2. Provide a statement regarding the individual's condition and medical circumstances relating to the individual are such that COVID-19 vaccination is not considered safe. Indicate the specific nature of the medical condition or circumstances that contraindicate immunization with a COVID-19 vaccine or might increase the risk for a serious adverse reaction.

3. Provide any other medical condition that would limit the employee from receiving any COVID-19 vaccine. Explain in detail the medical condition and the reasons why you believe the patient should not receive the COVID-19 vaccine.

Note that the CDC considers a history of the following to be a contraindication to vaccination with COVID-19 vaccines:

- Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a component of the COVID-19 vaccine;
- Immediate allergic reaction of any severity to a previous dose or known (diagnosed) allergy to a component (e.g. polyethylene glycol for Moderna of Pfizer and polysorbate 80 for J&J) of the COVID-19 vaccine.

Note that the following conditions are ***NOT*** considered contraindications for vaccination, pursuant to the CDC:

- Allergic reactions (including severe allergic reactions) not related to vaccines (COVID-19 or other vaccines) or injectable therapies, such as allergic reactions related to food, pet, venom, egg, gelatin, or environmental allergies, or allergies to oral medications (including the oral equivalents of injectable medications);
- Local reaction (e.g., erythema, induration, pruritus) around the injection site area.

In addition, the following generally would ***NOT*** be considered a contraindication, absent unusual clinical circumstances:

- Expected systemic vaccine side effects in previous COVID-19 vaccines (fever, chills, fatigue, headache, lymphadenopathy, vomiting, diarrhea, myalgia, arthralgia);
- Vasovagal reaction after receiving a dose of any vaccine;
- Being immunocompromised or receiving immunosuppressive medications;
- Autoimmune conditions, including Guillain-Barre Syndrome;
- Pregnancy or breastfeeding;
- Alpha-gal Syndrome

Healthcare Provider: _____

Name (print): _____ Address/Clinic Stamp: _____

Signature: _____Date:_____

Please submit this form to ADAcoordinator@ksu.edu or deliver to:

Human Capital Services
c/o ADA Coordinator
1810 Kerr Drive | 103 Edwards Hall
Manhattan, KS 66506

KANSAS STATE UNIVERSITY

Covid-19 Vaccine Religious Exemption Request

Mandatory COVID-Vaccine Policy

Kansas State University requires all employees to be fully vaccinated against COVID-19. This form should be used by employees who are requesting an exemption from the mandatory vaccine requirement due to a sincerely held religious belief, practice, or observance that conflicts with the vaccine requirement. While waiting for an exemption decision, employees must continue to follow university guidance on face coverings on campus and other safety measures.

To be eligible for a possible exemption, you must first establish that your refusal to be vaccinated is based upon a sincere belief that is religious in nature. A refusal to be vaccinated does not qualify for an exception if it is based upon personal preference, concerns about the possible effects of the vaccine, or political opinions. Employees must submit a written statement explaining the nature of their religious belief and how it conflicts with the COVID-19 vaccine requirement, and answer other questions presented on this form.

1. Employee Statement: Describe the sincerely held religious belief, practice, or observance that is the basis for your request for a religious exemption/accommodation to the university's COVID-19 vaccination requirement.

2. Would complying with the COVID-19 vaccination requirement substantially burden your religious exercise? If so, please explain how.

KANSAS STATE UNIVERSITY

3. How long have you held the above religious belief, practice, or observance?

4. Have you ever received a FDA authorized or approved vaccine at any time in your life? If so, please explain how your sincerely held religious belief, practice, or observance causes you to object to the COVID-19 vaccine compared to other vaccines you have received.

5. If there are any other medicines or products that you do not use because of the religious belief underlying your objection, please identify them.

6. If the request for exemption is temporary, please identify the anticipated date the exemption is no longer needed: _____

Other information or documentation supporting your request may be attached to this request form. Such supporting documentation may include, as applicable:

- Past documentation of medical and vaccination/immunization history that shows you acted in a manner consistent with your religious belief;
- Written religious materials describing the religious belief, practice, or observance; or
- Written statements or other documents from third parties, such as religious leaders, practitioners, or others with whom you have discussed your beliefs, or who have observed your past adherence to these beliefs.

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By signing this Religious Exemption Request, you attest that you cannot receive a COVID-19 vaccination because of the sincerely held religious belief, practice, or observance described above. If approved, you acknowledge that you will comply with applicable directives for unvaccinated individuals with exemptions, including wearing a face covering indoors and quarantining if exposed to COVID-19.

The undersigned verifies the truth and accuracy of the statements in this Religious Exemption Request and understands that providing false information may lead to disciplinary action up to and including termination.

Employee Name (Print): _____

Employee Signature: _____ Date: _____

Employee ID # _____

Please submit this form to religiousexemption@ksu.edu or deliver to:

Human Capital Services
c/o Religious Exemptions
1810 Kerr Drive | 103 Edwards Hall
Manhattan, KS 66506

KANSAS STATE UNIVERSITY

The American Disabilities Act (ADA) Coordinator assists applicants, employees, hiring officials, supervisors and managers in determining the essential functions of jobs and obtaining documentation of functional abilities and limitations, unless the limitations are obvious; researching and considering possible accommodations; and selecting an effective accommodation. The ADA Coordinator may collaborate with Student Access Center to ensure that students receive academic accommodations and with program sponsors to ensure that programs and activities are accessible.

PART I: REASONABLE ACCOMMODATION REQUEST FORM

This form is to be completed by Applicant/Employee (sometimes referred to as "requestor"), or Supervisor/Administrator to assist in a reasonable accommodation request. The form should be submitted to the Employee Relations, 103 Edwards Hall, 1810 Kerr Drive 785.532.6277 TRS: 711. Use of this form is not required to initiate a request. Requestors' use of this form is strongly encouraged, as it is provided as a tool to aid in the reasonable accommodation process. If the requestor does not complete the form, the ADA Coordinator may complete the form on the requestor's behalf after having been notified of a request.

PART II: HEALTH CARE PROVIDER FORM

If a requestor's disability and/or need for accommodation are not obvious or already known (e.g., from a previous request) to the University, the University is entitled to ask for and receive medical information showing that the requestor has a covered disability that requires accommodation. In those circumstances this form is to be completed by the appropriate health care professional. It is the responsibility of the requestor to see that this form is completed and submitted to Human Capital Services, Employee Relations, 103 Edwards Hall, 1810 Kerr Drive, 785.532.6277 TRS: 711. After receipt, and as part of processing the request (Part III), the ADA Coordinator will explain what additional information is needed from the professional, if any. The requestor should then ask his/her health care professional for the missing information, and the requestor shall provide it to the ADA Coordinator.

PART III: PROCESSING THE REQUEST

The ADA Coordinator shall contact the Applicant/Employee and the Supervisor/Administrator or other University official. If the Supervisor/Administrator receives the request, they will forward the request to the ADA Coordinator. The ADA Coordinator will work with the Supervisor/Administrator to gather relevant information necessary to respond to a request and to assess whether a particular accommodation will be effective. The individual requesting the accommodation must communicate with the Supervisor/Administrator and the ADA Coordinator about the request, the nature of the problem generating the request, how a disability is prompting a need for an accommodation, and alternative accommodations that may be effective in meeting the individual's needs. The ADA Coordinator also may require that the requestor undergo an independent medical examination. The ADA Coordinator and Supervisor/Administrator shall maintain confidentiality and only share information on a need to know basis or as otherwise permitted by applicable law. The University will process requests and, where appropriate, provide accommodations in a reasonable timeframe.

The Applicant/Employee should return this form to:

Human Capital Services, Employee Relations & Engagement,103 Edwards Hall, 1810 Kerr Drive Phone:785-532-6277 TRS:711
Fax:785-532-6095

KANSAS STATE UNIVERSITY

REASONABLE ACCOMMODATION REQUEST FORM

To be completed by Applicant/Employee or Supervisor/Administrator to aid in requesting a reasonable accommodation in the workplace

A. GENERAL INFORMATION

Applicant/Employee Information		Supervisor Information	
Applicant/ Employee's Name		**Supervisor's Name**	
Title		**Phone** (###-###-####)	
Department		**E-mail**	
Campus/Location			
Phone (###-###-####)			
E-mail			

B. QUESTIONS TO CLARIFY ACCOMMODATION REQUEST

1. Briefly, describe the disability/medical impairments for which you are requesting an accommodation.

2. What function of your job are you having difficulty with?

3. What specific accommodation are you requesting?

4. What other accommodations would be responsive to your request?

5. Check the appropriate box below (may check more than one box) and explain how the reasonable accommodation will assist you in:

☐ Application process

☐ Performing job functions or accessing the work environment

☐ Accessing a benefit or privilege of employment (e.g., attending training program or office event)

Explanation

6. Have you had any accommodations in the past for this same limitation? ☐ Yes ☐ No

If *yes*, what were they and how effective were they?

7. If you sought assistance from your supervisor, or from any other person, please provide the date and the result.

C. OTHER.
Please provide any additional information that might be useful in processing your accommodation request:
FMLA Notice: If you request leave for a serious health condition, you must also consult with your department Human Capital Liaison and comply with the department's usual and customary leave notice and procedures for requesting FMLA leave. See PPM Ch. 4860.040.

I affirm that all statements made above are true to the best of my knowledge and belief.

Applicant/Employee Signature	Date

The Applicant/Employee should return this form to:

Human Capital Services, Employee Relations & Engagement,103 Edwards Hall, 1810 Kerr Drive Phone:785-532-6277 TRS:711
Fax:785-532-6095

KANSAS STATE UNIVERSITY

HEALTH CARE PROVIDER FORM

TO BE COMPLETED BY APPLICANT/EMPLOYEE:	
Applicant/Employee's Name	
Provide a brief description of the disability/medical impairment for which you are requesting an accommodation.	

Instructions

We have been requested to consider a reasonable accommodation for the individual named above. An accommodation is a logical adjustment made to a job and/or the work environment that enables a qualified employee with a disability to successfully perform the essential duties or functions of the position. We request that you provide medical information which reflects:

- that the individual has one or more physical or mental impairment that substantially limit(s) one or more of his/her major life activities (e.g., walking, speaking, breathing, hearing, seeing, thinking, sitting, standing, reaching, interacting with others, learning, performing manual tasks, caring for oneself, concentrating, lifting, working, sleeping).
- that there is a relationship between the substantially limiting medical condition(s) and the requested accommodation.

NOTE: For your information, a copy of the appropriate job description is attached.

MEDICAL DOCUMENTATION

TO BE COMPLETED BY A HEALTH CARE PROVIDER, SOCIAL WORKER, OR REHABILITATION COUNSELOR:

1. Have you made a diagnosis that relates to this reasonable accommodation request? If yes, please state the diagnosis.

2. What is the disability/impairment(s) of the applicant/employee in regards to the description above?

3. Does the impairment substantially limit a major life activity compared to the general population, including but not limited to: walking, sleeping, hearing, or major bodily functions such as of the respiratory, immune, digestive, or other bodily system or functions? Please explain.

4. Please explain the impact of the limitation/impairment on major life activities listed above.

5. What accommodations do you believe are necessary to enable the applicant/employee to perform the essential functions of his/her job as a result of this condition?

6. What is the anticipated duration and frequency of this medical limitation/impairment?

7. Is it your opinion that your patient will be able to perform the essential function of his/her position safely and effectively if the reasonable accommodation he/she has requested is provided? ☐ Yes ☐ No

   If *no*, explain.

GINA Notice: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member of an embryo lawfully held by an individual or family member receiving assistive reproductive services.

The Applicant/Employee should return this form to:

Human Capital Services, Employee Relations & Engagement,103 Edwards Hall, 1810 Kerr Drive Phone:785-532-6277 TRS:711
Fax:785-532-6095

CERTIFICATION	
Health Care Practitioner, Social Worker, Rehabilitation Counselor Name	
Office Address	
Signature	Date