Request for Medical Accommodation
COVID-19 Vaccination Requirement

Authorization for Information (Applicant Completes this Section)

Name:	Show/Production:
Auditioning for: ☐ Cast ☐ Crew	Role or Job:
Phone:	Email:
Name of Health Care Provider:	Provider Phone:

I hereby authorize the above-named health care provider to complete this form and disclose to Valley Musical Theatre and its authorized representatives the following information related to my health care: the diagnosis(es) of relevant conditions, treatment plan(s), my ability to perform my work, recommendations, history, reports, and correspondence.

I understand that it may be necessary for the theatre representatives to share this information for purposes related to accommodation of a disability. I authorize the theatre to share this information among appropriate staff and authorized representatives to the extent necessary to determine whether accommodation is necessary and to administer the accommodation process. My health record may include information related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV) behavioral or mental health services, and treatment for alcohol and drug abuse.

Once disclosed, the law does not always require the recipient of my information to maintain the confidentiality of my health care information. I understand that I have the following rights: a) to inspect or receive a copy of my protected health information, b) to receive a copy of this signed authorization, and c) to refuse to sign this authorization. I understand that information obtained under this release is a confidential medical record and is maintained separate from files related to this production. This authorization is valid for 90 days after the date of my signature below. However, I understand that I may revoke this consent, in writing, at any time except to the extent that action has already been taken based on the original authorization. I also understand that the above-named health care provider will not condition treatment or payment based on receipt of this signed authorization.

I hereby authorize my health care provider to discuss directly with a Valley Musical Theatre representative any medical/mental health information relevant to my accommodation request. By signing this page, I acknowledge that I have read and agree to the terms described above. (NOTE to applicant: If you do not provide authorization for your health care provider to discuss the medical/mental health information relevant to your accommodation request, processing of your accommodation request may be delayed.)

Signature:	Date:

Forward this form to your health care provider! A copy of this signed form should be turned in with your exemption form at the audition.

COVID-19 Vaccination Medical Exemption Form

To Cast/Crew applicants for VMT Productions: This form must be completed by a licensed health care provider (MD, DO, ND, ARNP, PA). The reviewing health care provider is required to be licensed in the state of Washington. The completed form must be presented in person at the audition. Electronic copies will not be accepted.

Health care provider: Please complete the form and return it to your patient who will then submit it to Valley Musical Theatre.

Patient Section

Patient Name_____

Date of Birth_____ Email_____

Select the medical contraindication(s) to COVID-19 vaccination below:

☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a component of a COVID-19 vaccine. Please describe response in detail below and contraindication to alternatives in order for this request to be considered by the organization.

This condition or circumstance is: temporary permanent
If temporary, provide the anticipated time range:_____

☐ Immediate allergic reaction to a previous dose or known (diagnosed) allergy to a component of the vaccine. Please describe response in detail below and contraindication to alternative vaccines.

This condition or circumstance is: temporary permanent
If temporary, provide the anticipated time range:_____

☐ Other medical circumstance preventing vaccination with any available COVID-19 vaccine. Please describe response in detail below and contraindication to alternative vaccines.

This condition or circumstance is: temporary permanent
If temporary, provide the anticipated time range:_____

☐ COVID-19 vaccination clinical trial participant. A licensed healthcare provider (MD, DO, ND, ARNP, PA) of the clinical trial team must sign this form as verification of enrollment.

Provider information and signature

Health Care Provider information (required for medical request):

Printed name: _____ Date: _____

Provider signature: _____

Select: ☐MD ☐DO ☐ND ☐ARNP ☐PA

License #_____ NPI #_____ State:_____

Medical facility name: _____ Phone number: _____

Address:_____