I authorize my treating physician(s) or healthcare provider(s) to complete the below questionnaire and disclose any and all related health or medical information regarding me in connection with my request for workplace accommodations. Please return this questionnaire directly to IntelyCare by uploading in app or by email to credentialing@intelycare.com or by fax at 617-984-5332 and to respond to any follow up questions IntelyCare, Inc. may have related to the below.

_____ Dated: _____

Signed by [insert employee name]

INTELYCARE, INC. HEALTH CARE PROVIDER QUESTIONAIRE FOR AMERICANS WITH DISABILITIES (ADA) ACCOMMODATION CONCERNING COVID-19 VACCINATION POLICY

Patient Name _____

Your patient has requested an accommodation under state and federal law from IntelyCare, Inc.'s (IntelyCare) concerning IntelyCare client policies which require a COVID-19 vaccination as a condition of providing in-person nursing care (in-person work is a job requirement). Per the above authorization, patient has authorized you to complete the following form so that IntelyCare may better determine whether reasonable accommodation is appropriate. ***Please return this questionnaire fully completed by _____ __, 2021.***

1. Does the patient have a physical or mental ***underlying condition*** that contraindicates a COVID-19 vaccination?

   Yes ☐ No ☐

2. If yes, please describe why the patient is contraindicated for vaccination, but do NOT identify the underlying condition or provide any genetic information regarding the patient: _____
   _____
   _____

3. What risks would be posed to patient by COVID-19 vaccination?:
   _____
   _____

4. Is patient contraindicated for all vaccines, or just a specific one (i.e., Pfizer, Moderna, Johnson & Johnson)?

_____
_____

5. Is the patient currently under your care? Yes ☐ No ☐

6. How long has the patient been under your care? Since: _____

7. When did the condition begin: _____/_____/_____

8. When is the underlying condition likely to end? _____/_____/_____ OR

   ☐ Permanent or
   ☐ Unable to determine

CERTIFICATION: I certify that the above-named individual be granted a medical exemption from the Facility's COVID-19 vaccination requirement because I have determined that the administration of a COVID-19 vaccine would be detrimental to the individual's health.

Provider Name _____

Provider Signature _____

Provider Address _____

Provider Telephone Number_____

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