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ATTORNEYS AT LAW

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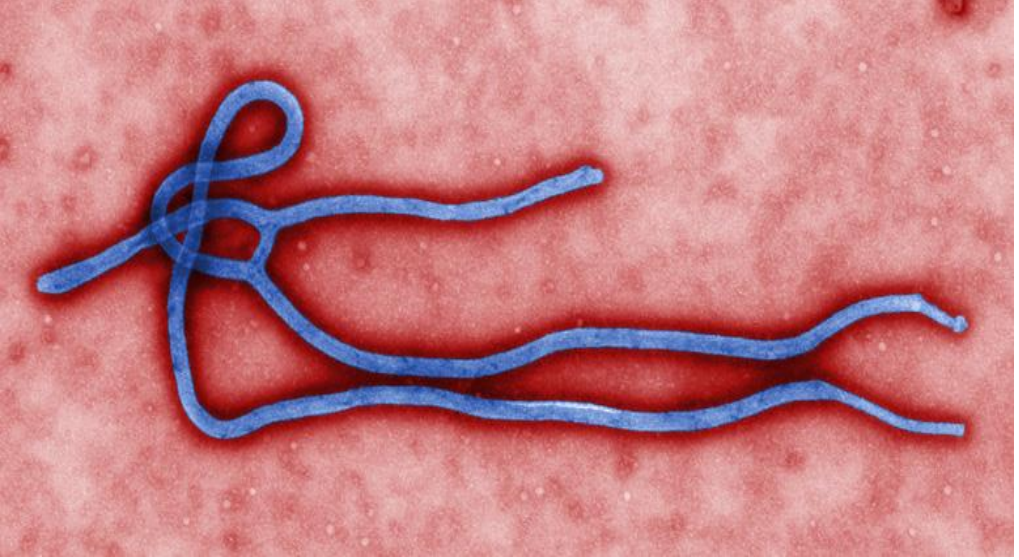
Today's webinar will begin shortly. We are waiting for attendees to log on.

Presented by:

Howard A. Mavity
Kevin Troutman



A Balanced Analysis of Workplace Ebola Concerns

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OVERREACTION? (from the Huffington Post)

- Teachers and students across the country have stayed home in response to concerns over Ebola. In Maine, an elementary school teacher was recently put on paid leave for up to three weeks after parents complained that the teacher had traveled to Dallas, where there have been a few Ebola cases. On Sunday, a similar precaution was taken at a high school in Phenix, Alabama, after an employee flew on the same plane as a person who contracted Ebola -- even though the employee flew a day later, long after the aircraft had been cleaned.

OVERREACTION?

- Last week, kids were asked to stay home from school in Shaker Heights and Solon, Ohio, over Ebola fears. A New Jersey elementary school reported on Saturday that two students from Rwanda -- a country not hit by Ebola -- would stay home for three weeks after parents complained that they may spread the virus. In Pennsylvania, a high school soccer team allegedly chanted offensive "Ebola" taunts to a teenager from Guinea. (from the Huffington Post)

HOW SHOULD WE REACT?

- It's ok to be scared. This is scary stuff!
- But knee jerk reactions get one sued and create other legal issues.
- Approach Ebola issues as a Risk Management analysis.
- Ebola raises questions but WHO and the CDC have over 30 years of experience and the past containment of many Ebola outbreaks.
- CDC reactions and their approach raise questions, but information proffered about Ebola seems accurate.
  - Especially in early stages, transmission opportunities are limited.
  - Not airborne.
  - Most dangerous to Healthcare Workers (hug a nurse!)

HOW SHOULD WE REACT?

- Other regulators follow the CDC's lead.
- But, especially in early stages, public health guidance does not cleanly apply to specific employer scenarios.
- One must extrapolate to apply disease-driven guidance to heavily regulated employment scenarios.
- Neither the CDC Guidance or EEOC application take a "better safe than sorry approach."
- "Direct threat" under the ADA is difficult to prove.
- Employee, public and customer concerns mean almost nothing to these regulators.

SO, WE'RE BACK TO RISK MANAGEMENT.

- Objectively weigh ALL risks, and the dollar and human costs.
  - Monitor the evolution of public health guidance because, generally, as we learn more, public health guidance tends to find less threat presented by a disease and its sufferers.
  - Determine your disease exposure;
  - And the applicable legal concerns:
    - ADA confidentially and common law privacy and defamation.
    - ADA and state protections of employees with a disability condition or those wrongly perceived to have a disability condition.
    - Race and national origin discrimination;
    - Contract.

RISK MANAGEMENT STEP ONE: EVALUATING THE RISK OF TRANSMISSION.

- How is it transmitted?
- How easy is it to get it?

CHALLENGES IN IDENTIFYING EBOLA

- **Symptoms of Ebola include**
- Fever
- Severe headache
- Muscle pain
- Weakness
- Diarrhea
- Vomiting
- Abdominal (stomach) pain
- Unexplained hemorrhage (bleeding or bruising)
- Symptoms may appear anywhere from 2 to 21 days after exposure to Ebola, but the average is 8 to 10 days.

CASE DEFINITION FOR EBOLA

- **Person Under Investigation (PUI)**
- A person who has both consistent symptoms and risk factors as follows:
- Clinical criteria, which includes fever of greater than 38.6 degrees Celsius or 101.5 degrees Fahrenheit, and additional symptoms such as severe headache, muscle pain, vomiting, diarrhea, abdominal pain, or unexplained hemorrhage; AND
- epidemiologic risk factors within the past 21 days before the onset of symptoms, such as contact with blood or other body fluids or human remains of a patient known to have or suspected to have EVD; residence in—or travel to—an area where EVD transmission is active*; or direct handling of bats or non-human primates from disease-endemic areas

PROBABLE CASE: A PUI WHOSE EPIDEMIOLOGIC RISK FACTORS INCLUDE HIGH OR LOW RISK EXPOSURE(S) (SEE BELOW)

A high risk exposure includes any of the following:

- Percutaneous (e.g., needle stick) or mucous membrane exposure to blood or body fluids of EVD patient
- Direct skin contact with, or exposure to blood or body fluids of, an EVD patient without appropriate personal protective equipment (PPE)
- Processing blood or body fluids of a confirmed EVD patient without appropriate PPE or standard biosafety precautions
- Direct contact with a dead body without appropriate PPE in a country where an EVD outbreak is occurring*

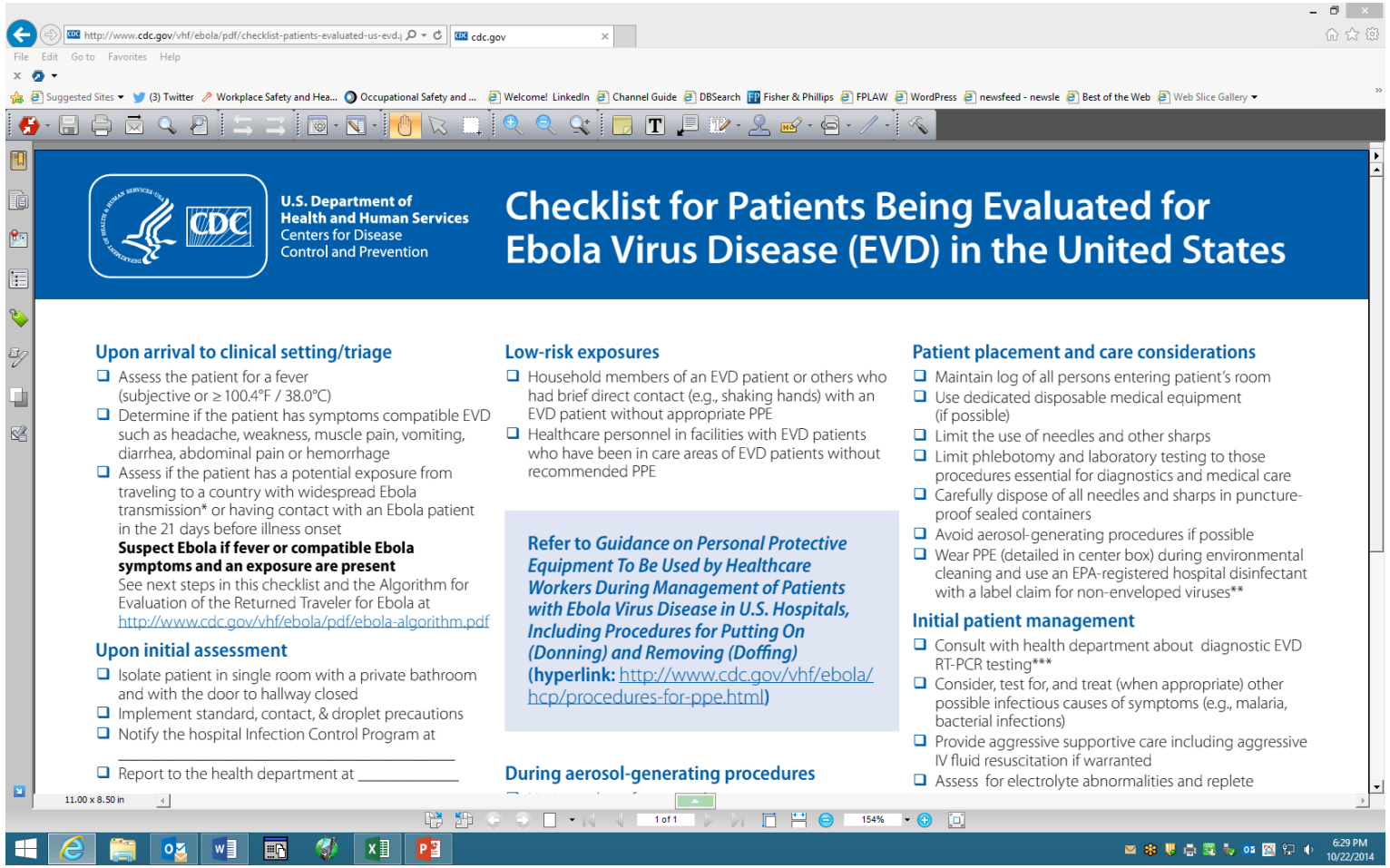
A low risk exposure includes any of the following

- Household contact with an EVD patient
- Other close contact with EVD patients in health care facilities or community settings. Close contact is defined as
  - being within approximately 3 feet (1 meter) of an EVD patient or within the patient's room or care area for a prolonged period of time (e.g., health care personnel, household members) while not wearing recommended personal protective equipment (i.e., standard, droplet, and contact precautions; see Infection Prevention and Control Recommendations(http://www.cdc.gov/vhf/ebola/hcp/patient-management-us-hospitals.html))
  - having direct brief contact (e.g., shaking hands) with an EVD patient while not wearing recommended personal protective equipment.
- Brief interactions, such as walking by a person or moving through a hospital, do not constitute close contact

INTERIM GUIDANCE FOR MONITORING AND MOVEMENT OF PERSONS WITH EBOLA VIRUS DISEASE EXPOSURE

- **Close contact**
- Close contact is defined as
- being within approximately 3 feet (1 meter) of an EVD patient or within the patient's room or care area for a prolonged period of time (e.g., health care personnel, household members) while not wearing recommended personal protective equipment (i.e., standard, droplet, and contact precautions; see Infection Prevention and Control Recommendations); or
- having direct brief contact (e.g., shaking hands) with an EVD patient while not wearing recommended personal protective equipment.
- Brief interactions, such as walking by a person or moving through a hospital, do not constitute close contact.

EBOLA CHECKLIST PATIENT EVALUATION



U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

Checklist for Patients Being Evaluated for Ebola Virus Disease (EVD) in the United States

Upon arrival to clinical setting/triage

- ❑ Assess the patient for a fever (subjective or ≥ 100.4°F / 38.0°C)
- ❑ Determine if the patient has symptoms compatible EVD such as headache, weakness, muscle pain, vomiting, diarrhea, abdominal pain or hemorrhage
- ❑ Assess if the patient has a potential exposure from traveling to a country with widespread Ebola transmission* or having contact with an Ebola patient in the 21 days before illness onset

Suspect Ebola if fever or compatible Ebola symptoms and an exposure are present

See next steps in this checklist and the Algorithm for Evaluation of the Returned Traveler for Ebola at http://www.cdc.gov/vhf/ebola/pdf/ebola-algorithm.pdf

Upon initial assessment

- ❑ Isolate patient in single room with a private bathroom and with the door to hallway closed
- ❑ Implement standard, contact, & droplet precautions
- ❑ Notify the hospital Infection Control Program at _____
- ❑ Report to the health department at _____

Low-risk exposures

- ❑ Household members of an EVD patient or others who had brief direct contact (e.g., shaking hands) with an EVD patient without appropriate PPE
- ❑ Healthcare personnel in facilities with EVD patients who have been in care areas of EVD patients without recommended PPE

Refer to Guidance on Personal Protective Equipment To Be Used by Healthcare Workers During Management of Patients with Ebola Virus Disease in U.S. Hospitals, Including Procedures for Putting On (Donning) and Removing (Doffing)
(hyperlink: http://www.cdc.gov/vhf/ebola/hcp/procedures-for-ppe.html**)**

During aerosol-generating procedures

Patient placement and care considerations

- ❑ Maintain log of all persons entering patient's room
- ❑ Use dedicated disposable medical equipment (if possible)
- ❑ Limit the use of needles and other sharps
- ❑ Limit phlebotomy and laboratory testing to those procedures essential for diagnostics and medical care
- ❑ Carefully dispose of all needles and sharps in puncture-proof sealed containers
- ❑ Avoid aerosol-generating procedures if possible
- ❑ Wear PPE (detailed in center box) during environmental cleaning and use an EPA-registered hospital disinfectant with a label claim for non-enveloped viruses**

Initial patient management

- ❑ Consult with health department about diagnostic EVD RT-PCR testing***
- ❑ Consider, test for, and treat (when appropriate) other possible infectious causes of symptoms (e.g., malaria, bacterial infections)
- ❑ Provide aggressive supportive care including aggressive IV fluid resuscitation if warranted
- ❑ Assess for electrolyte abnormalities and replete

HOW THE CDC TRACKS POSIBLE EXPOSURE

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Press Release

For Immediate Release: Wednesday, October 8
Contact: CDC Media Relations
(404) 639-3286

Enhanced Ebola Screening to Start at Five U.S. Airports and New Tracking Program for all People Entering U.S. from Ebola-affected Countries

New layers of screening at airports that receive more than 94% of West African Travelers

The Centers for Disease Control and Prevention (CDC) and the Department of Homeland Security's Customs & Border Protection (CBP) this week will begin new layers of entry screening at five U.S. airports that receive over 94 percent of travelers from the Ebola-affected nations of Guinea, Liberia, and Sierra Leone.

New York's JFK International Airport will begin the new screening on Saturday. In the 12 months ending July 2014, JFK received nearly half of travelers from the three West African nations. The enhanced entry screening at Washington-Dulles, Newark, Chicago-O'Hare, and Atlanta international airports will be implemented next week.

Joint Airport Screening Fact Sheet (English)
Joint Airport Screening Fact Sheet (Spanish)
Joint Airport Screening Fact Sheet (French)

"We work to continuously increase the safety of Americans," said CDC Director Tom Frieden, M.D., M.P.H. "We believe these new measures will further protect the health of Americans, understanding that nothing we can do will get us to absolute zero risk until we end the Ebola epidemic in West Africa."

"CBP personnel will continue to observe all travelers entering the United States for general overt signs of illnesses at all U.S. ports of entry and these expanded screening measures will provide an additional layer of protection to help ensure the risk of Ebola in the United States is minimized," said Secretary of Homeland Security Jeh Johnson. "CBP, working closely with CDC, will continue to assess the risk of the spread of Ebola into the United States, and take additional measures, as necessary, to protect the American people."

CDC is sending additional staff to each of the five airports. After passport review:

- Travelers from Guinea, Liberia, and Sierra Leone will be escorted by CBP to an area of the

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Atlanta, GA 30333

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TTY: (888) 232-6348
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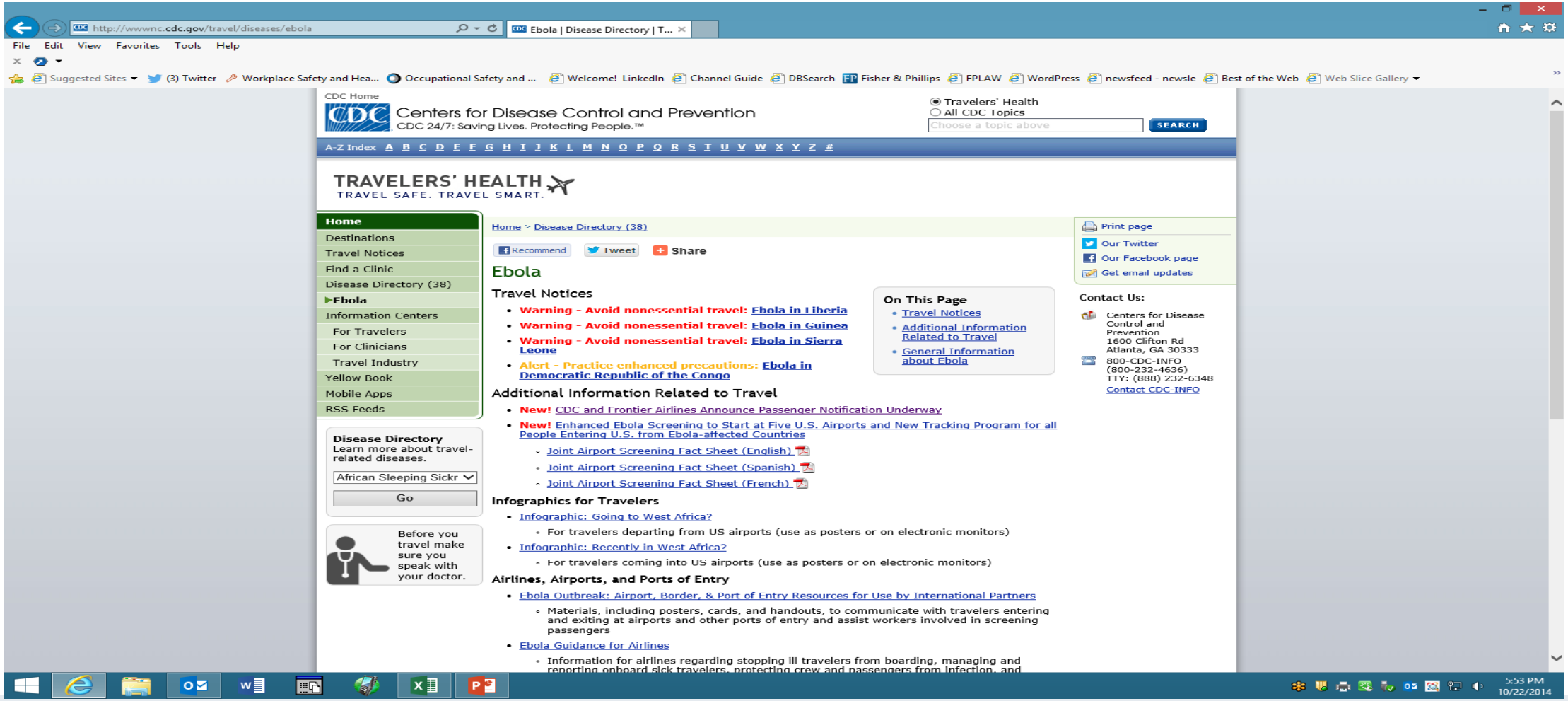
- CDC is sending additional staff to each of the five airports. After passport review:
- Travelers from Guinea, Liberia, and Sierra Leone will be escorted by CBP to an area of the airport set aside for screening.
- Trained CBP staff will observe them for signs of illness, ask them a series of health and exposure questions and provide health information for Ebola and reminders to monitor themselves for symptoms. Trained medical staff will take their temperature with a non-contact thermometer.
- If the travelers have fever, symptoms or the health questionnaire reveals possible Ebola exposure, they will be evaluated by a CDC quarantine station public health officer. The public health officer will again take a temperature reading and make a public health assessment. Travelers, who after this assessment, are determined to require further evaluation or monitoring will be referred to the appropriate public health authority.
- Travelers from these countries who have neither symptoms/fever nor a known history of exposure will receive health information for self-monitoring.



SO HOW DOES THE CDC APPLY THIS ANALYSIS TO RETURNING TRAVELERS?

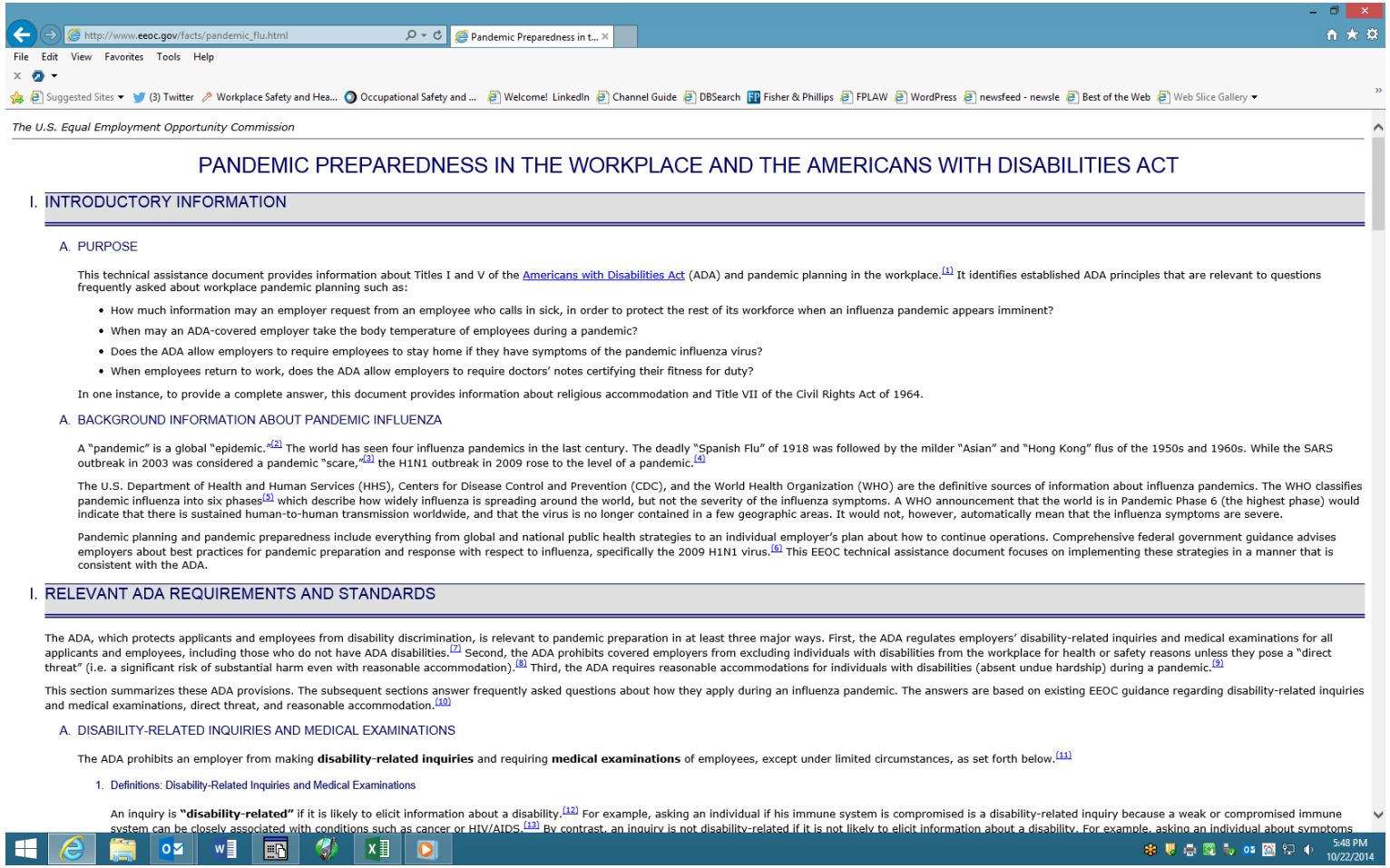
FROM CDC: *SHOULD COLLEGES AND UNIVERSITIES ISOLATE OR QUARANTINE STUDENTS AND FACULTY WHO HAVE RECENTLY RETURNED TO THE US FROM COUNTRIES WHERE THE EBOLA OUTBREAKS ARE OCCURRING?*

- **CDC is not recommending colleges and universities isolate or quarantine students, faculty, or staff based on travel history alone.**
- Colleges and universities should identify students, faculty, and staff who have been in countries where Ebola outbreaks are occurring within the past 21 days and should conduct a risk assessment with each identified person to determine his or her level of risk exposure (high- or low-risk exposures, or no known exposure).
- All students, faculty, and staff who have been in these countries within the past 21 days should be given instructions for health monitoring (see below).
- If the students have had **NO symptoms of Ebola for 21 days** since leaving a West African country with Ebola outbreaks, **they do NOT have Ebola**. *No further assessment is needed*.
- If a student, faculty, or staff member has had a high- or low-risk exposure, state or local public health authorities should be notified, and school officials should consult with public health authorities for guidance about how that person should be monitored. Anyone with a potential exposure should receive thorough education about immediately reporting symptoms and staying away from other people if symptoms develop.
- In the event that a person who has had a high- or low-risk exposure develops symptoms consistent with Ebola, the person should be medically evaluated while following recommended infection control precautions

THE ADA ANALYSIS

- The traveler returning from an affected country?
- The traveler from Nigeria?
- The traveler from East Africa?
- The passenger on a plane with an infected person?
- A person at a conference with an infected person?
- The coworker asking about a colleague who traveled to Liberia?
- Customers refusing to work with a salesperson who was in Nigeria?
- Medical inquiries and taking temperature?
- A desire to brief coworkers?

EEOC PANDEMIC PLANNING MEETS ADA



http://www.eeoc.gov/facts/pandemic_flu.html

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The U.S. Equal Employment Opportunity Commission

PANDEMIC PREPAREDNESS IN THE WORKPLACE AND THE AMERICANS WITH DISABILITIES ACT

I. INTRODUCTORY INFORMATION

A. PURPOSE

This technical assistance document provides information about Titles I and V of the Americans with Disabilities Act (ADA) and pandemic planning in the workplace.[1] It identifies established ADA principles that are relevant to questions frequently asked about workplace pandemic planning such as:

- How much information may an employer request from an employee who calls in sick, in order to protect the rest of its workforce when an influenza pandemic appears imminent?
- When may an ADA-covered employer take the body temperature of employees during a pandemic?
- Does the ADA allow employers to require employees to stay home if they have symptoms of the pandemic influenza virus?
- When employees return to work, does the ADA allow employers to require doctors' notes certifying their fitness for duty?

In one instance, to provide a complete answer, this document provides information about religious accommodation and Title VII of the Civil Rights Act of 1964.

A. BACKGROUND INFORMATION ABOUT PANDEMIC INFLUENZA

A "pandemic" is a global "epidemic."[2] The world has seen four influenza pandemics in the last century. The deadly "Spanish Flu" of 1918 was followed by the milder "Asian" and "Hong Kong" flus of the 1950s and 1960s. While the SARS outbreak in 2003 was considered a pandemic "scare,"[3] the H1N1 outbreak in 2009 rose to the level of a pandemic.[4]

The U.S. Department of Health and Human Services (HHS), Centers for Disease Control and Prevention (CDC), and the World Health Organization (WHO) are the definitive sources of information about influenza pandemics. The WHO classifies pandemic influenza into six phases[5] which describe how widely influenza is spreading around the world, but not the severity of the influenza symptoms. A WHO announcement that the world is in Pandemic Phase 6 (the highest phase) would indicate that there is sustained human-to-human transmission worldwide, and that the virus is no longer contained in a few geographic areas. It would not, however, automatically mean that the influenza symptoms are severe.

Pandemic planning and pandemic preparedness include everything from global and national public health strategies to an individual employer's plan about how to continue operations. Comprehensive federal government guidance advises employers about best practices for pandemic preparation and response with respect to influenza, specifically the 2009 H1N1 virus.[6] This EEOC technical assistance document focuses on implementing these strategies in a manner that is consistent with the ADA.

I. RELEVANT ADA REQUIREMENTS AND STANDARDS

The ADA, which protects applicants and employees from disability discrimination, is relevant to pandemic preparation in at least three major ways. First, the ADA regulates employers' disability-related inquiries and medical examinations for all applicants and employees, including those who do not have ADA disabilities.[7] Second, the ADA prohibits covered employers from excluding individuals with disabilities from the workplace for health or safety reasons unless they pose a "direct threat" (i.e. a significant risk of substantial harm even with reasonable accommodation).[8] Third, the ADA requires reasonable accommodations for individuals with disabilities (absent undue hardship) during a pandemic.[9]

This section summarizes these ADA provisions. The subsequent sections answer frequently asked questions about how they apply during an influenza pandemic. The answers are based on existing EEOC guidance regarding disability-related inquiries and medical examinations, direct threat, and reasonable accommodation.[10]

A. DISABILITY-RELATED INQUIRIES AND MEDICAL EXAMINATIONS

The ADA prohibits an employer from making **disability-related inquiries** and requiring **medical examinations** of employees, except under limited circumstances, as set forth below.[11]

1. Definitions: Disability-Related Inquiries and Medical Examinations

An inquiry is **"disability-related"** if it is likely to elicit information about a disability.[12] For example, asking an individual if his immune system is compromised is a disability-related inquiry because a weak or compromised immune system can be closely associated with conditions such as cancer or HIV/AIDS.[13] By contrast, an inquiry is not disability-related if it is not likely to elicit information about a disability. For example, asking an individual about symptoms

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WHAT THE EEOC GUIDANCE COVERS.

- Information about Titles I and V of the Americans with Disabilities Act (ADA) and pandemic planning in the workplace. It identifies established ADA principles that are relevant to questions frequently asked about workplace pandemic planning such as:
  - How much information may an employer request from an employee who calls in sick, in order to protect the rest of its workforce when an influenza pandemic appears imminent?
  - When may an ADA-covered employer take the body temperature of employees during a pandemic?
  - Does the ADA allow employers to require employees to stay home if they have symptoms of the pandemic influenza virus?
  - When employees return to work, does the ADA allow employers to require doctors' notes certifying their fitness for duty?

THE EEOC ON DIRECT THREAT IN A PANDEMIC

- **Direct threat** is an important ADA concept during an influenza pandemic.
- Whether pandemic influenza rises to the level of a direct threat depends on the severity of the illness. If the CDC or state or local public health authorities determine that the illness is like seasonal influenza or the 2009 spring/summer H1N1 influenza, it would not pose a direct threat or justify disability-related inquiries and medical examinations. By contrast, if the CDC or state or local health authorities determine that pandemic influenza is significantly more severe, it could pose a direct threat. The assessment by the CDC or public health authorities would provide the objective evidence needed for a disability-related inquiry or medical examination.
- During a pandemic, employers should rely on the latest CDC and state or local public health assessments. While the EEOC recognizes that public health recommendations may change during a crisis and differ between states, employers are expected to make their best efforts to obtain public health advice that is contemporaneous and appropriate for their location, and to make reasonable assessments of conditions in their workplace based on this information.

MAY AN ADA-COVERED EMPLOYER SEND EMPLOYEES HOME IF THEY DISPLAY INFLUENZA-LIKE SYMPTOMS DURING A PANDEMIC?

Yes. The CDC states that employees who become ill with symptoms of influenza-like illness at work during a pandemic should leave the workplace. Advising such workers to go home is not a disability-related action if the illness is akin to seasonal influenza or the 2009 spring/summer H1N1 virus. Additionally, the action would be permitted under the ADA if the illness were serious enough to pose a direct threat.

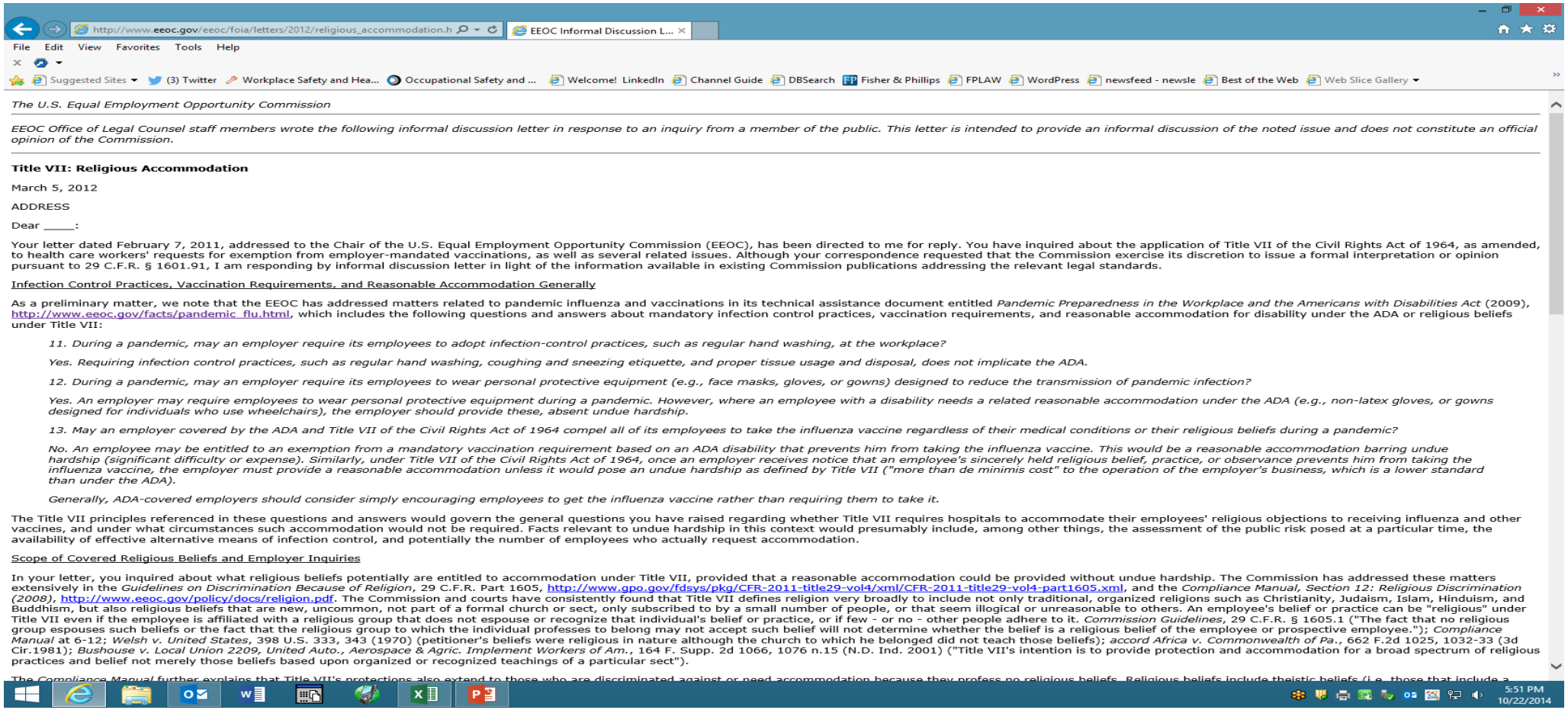
DURING A PANDEMIC, HOW MUCH INFORMATION MAY AN ADA-COVERED EMPLOYER REQUEST FROM EMPLOYEES WHO REPORT FEELING ILL AT WORK OR WHO CALL IN SICK?

- ADA-covered employers may ask such employees if they are experiencing influenza-like symptoms, such as fever or chills and a cough or sore throat. Employers must maintain all information about employee illness as a confidential medical record in compliance with the ADA.
- If pandemic influenza is like seasonal influenza or spring/summer 2009 H1N1, these inquiries are not disability-related. If pandemic influenza becomes severe, the inquiries, even if disability-related, are justified by a reasonable belief based on objective evidence that the severe form of pandemic influenza poses a direct threat.

WHEN AN EMPLOYEE RETURNS FROM TRAVEL DURING A PANDEMIC, MUST AN EMPLOYER WAIT UNTIL THE EMPLOYEE DEVELOPS INFLUENZA SYMPTOMS TO ASK QUESTIONS ABOUT EXPOSURE TO PANDEMIC INFLUENZA DURING THE TRIP?

No. These would not be disability-related inquiries. If the CDC or state or local public health officials recommend that people who visit specified locations remain at home for several days until it is clear they do not have pandemic influenza symptoms, an employer may ask whether employees are returning from these locations, even if the travel was personal.

RELIGIOUS ACCOMODATION



http://www.eeoc.gov/eeoc/foia/letters/2012/religious_accommodation.h

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The U.S. Equal Employment Opportunity Commission

EEOC Office of Legal Counsel staff members wrote the following informal discussion letter in response to an inquiry from a member of the public. This letter is intended to provide an informal discussion of the noted issue and does not constitute an official opinion of the Commission.

Title VII: Religious Accommodation

March 5, 2012

ADDRESS

Dear _____:

Your letter dated February 7, 2011, addressed to the Chair of the U.S. Equal Employment Opportunity Commission (EEOC), has been directed to me for reply. You have inquired about the application of Title VII of the Civil Rights Act of 1964, as amended, to health care workers' requests for exemption from employer-mandated vaccinations, as well as several related issues. Although your correspondence requested that the Commission exercise its discretion to issue a formal interpretation or opinion pursuant to 29 C.F.R. § 1601.91, I am responding by informal discussion letter in light of the information available in existing Commission publications addressing the relevant legal standards.

Infection Control Practices, Vaccination Requirements, and Reasonable Accommodation Generally

As a preliminary matter, we note that the EEOC has addressed matters related to pandemic influenza and vaccinations in its technical assistance document entitled *Pandemic Preparedness in the Workplace and the Americans with Disabilities Act* (2009), http://www.eeoc.gov/facts/pandemic_flu.html, which includes the following questions and answers about mandatory infection control practices, vaccination requirements, and reasonable accommodation for disability under the ADA or religious beliefs under Title VII:

> *11. During a pandemic, may an employer require its employees to adopt infection-control practices, such as regular hand washing, at the workplace?*
>
> *Yes. Requiring infection control practices, such as regular hand washing, coughing and sneezing etiquette, and proper tissue usage and disposal, does not implicate the ADA.*
>
> *12. During a pandemic, may an employer require its employees to wear personal protective equipment (e.g., face masks, gloves, or gowns) designed to reduce the transmission of pandemic infection?*
>
> *Yes. An employer may require employees to wear personal protective equipment during a pandemic. However, where an employee with a disability needs a related reasonable accommodation under the ADA (e.g., non-latex gloves, or gowns designed for individuals who use wheelchairs), the employer should provide these, absent undue hardship.*
>
> *13. May an employer covered by the ADA and Title VII of the Civil Rights Act of 1964 compel all of its employees to take the influenza vaccine regardless of their medical conditions or their religious beliefs during a pandemic?*
>
> *No. An employee may be entitled to an exemption from a mandatory vaccination requirement based on an ADA disability that prevents him from taking the influenza vaccine. This would be a reasonable accommodation barring undue hardship (significant difficulty or expense). Similarly, under Title VII of the Civil Rights Act of 1964, once an employer receives notice that an employee's sincerely held religious belief, practice, or observance prevents him from taking the influenza vaccine, the employer must provide a reasonable accommodation unless it would pose an undue hardship as defined by Title VII ("more than de minimis cost" to the operation of the employer's business, which is a lower standard than under the ADA).*
>
> *Generally, ADA-covered employers should consider simply encouraging employees to get the influenza vaccine rather than requiring them to take it.*

The Title VII principles referenced in these questions and answers would govern the general questions you have raised regarding whether Title VII requires hospitals to accommodate their employees' religious objections to receiving influenza and other vaccines, and under what circumstances such accommodation would not be required. Facts relevant to undue hardship in this context would presumably include, among other things, the assessment of the public risk posed at a particular time, the availability of effective alternative means of infection control, and potentially the number of employees who actually request accommodation.

Scope of Covered Religious Beliefs and Employer Inquiries

In your letter, you inquired about what religious beliefs potentially are entitled to accommodation under Title VII, provided that a reasonable accommodation could be provided without undue hardship. The Commission has addressed these matters extensively in the *Guidelines on Discrimination Because of Religion*, 29 C.F.R. Part 1605, http://www.gpo.gov/fdsys/pkg/CFR-2011-title29-vol4/xml/CFR-2011-title29-vol4-part1605.xml, and the *Compliance Manual, Section 12: Religious Discrimination (2008)*, http://www.eeoc.gov/policy/docs/religion.pdf. The Commission and courts have consistently found that Title VII defines religion very broadly to include not only traditional, organized religions such as Christianity, Judaism, Islam, Hinduism, and Buddhism, but also religious beliefs that are new, uncommon, not part of a formal church or sect, only subscribed to by a small number of people, or that seem illogical or unreasonable to others. An employee's belief or practice can be "religious" under Title VII even if the employee is affiliated with a religious group that does not espouse or recognize that individual's belief or practice, or if few - or no - other people adhere to it. *Commission Guidelines*, 29 C.F.R. § 1605.1 ("The fact that no religious group espouses such beliefs or the fact that the religious group to which the individual professes to belong may not accept such belief will not determine whether the belief is a religious belief of the employee or prospective employee."); *Compliance Manual* at 6-12; *Welsh v. United States*, 398 U.S. 333, 343 (1970) (petitioner's beliefs were religious in nature although the church to which he belonged did not teach those beliefs); *accord Africa v. Commonwealth of Pa.*, 662 F.2d 1025, 1032-33 (3d Cir.1981); *Bushouse v. Local Union 2209, United Auto., Aerospace & Agric. Implement Workers of Am.*, 164 F. Supp. 2d 1066, 1076 n.15 (N.D. Ind. 2001) ("Title VII's intention is to provide protection and accommodation for a broad spectrum of religious practices and belief not merely those beliefs based upon organized or recognized teachings of a particular sect").

The *Compliance Manual* further explains that Title VII's protections also extend to those who are discriminated against or need accommodation because they profess no religious beliefs. Religious beliefs include theistic beliefs (i.e. those that include a

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COMPLAINTS AND REFUSAL TO WORK.

- OSHA 11C prohibits adverse action against an employee for complaining about safety even if the complaint is unfounded.
- However, if an employee refuses to work based on safety concerns must be objectively reasonable.
- Employee complaints or refusal to work may be protected as concerted protective activity under the National Labor Relations Act.

WHAT'S SAFE?

- CDC new Guidance for Healthcare workers. http://www.cdc.gov/vhf/ebola/hcp/infection-prevention-and-control-recommendations.html
- OSHA Page regarding Ebola. https://www.osha.gov/SLTC/ebola/index.html
- OSHA Page regarding Influenza Pandemic. https://www.osha.gov/Publications/3328-05-2007-English.html
- OSHA Guidance on clean up after Ebola. https://www.osha.gov/Publications/OSHA_FS-3756.pdf
- CDC PPE instruction. http://www.cdc.gov/vhf/ebola/hcp/procedures-for-ppe.html

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Thank You!

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