REQUEST FOR TEMPORARY WORK ADJUSTMENT FOR AN INDIVIDUAL AT HIGH RISK FOR SEVERE ILLNESS FROM COVID-19

Employee Information

Name: _____ Employee ID # _____

Email Address: _____ Home/Cell Phone: _____

Department: _____ Work Phone: _____

Supervisor: _____ Payroll Reporter: _____

Employee Certification

I hereby certify:

☐ I meet one or more of the CDC's criteria to be considered an individual at high risk (set forth in the Health Care Certification below).

☐ I live with _____, who is an individual who meets one or more of the high risk criteria below and I am unable to adjust my living situation to avoid close contact with them.

☐ I am age sixty-five (65) or older or live with an individual who is age sixty-five (65) or older.

I am requesting the following temporary work adjustment (see guidelines on page 2):

☐ Unpaid Leave of Absence from _____ to _____.

☐ Working remotely from _____ to _____.

☐ Other: _____

Employee Signature: _____ Date: _____

Health Care Provider Certification

I hereby certify that the above-referenced individual meets one or more of the following criteria:

☐ The individual has chronic lung disease or moderate to severe asthma.

☐ The individual has a serious heart condition.

☐ The individual is immunocompromised (many conditions can cause a person to be immunocompromised, including cancer treatment, smoking, bone marrow or organ transplantation, immune deficiencies, poorly controlled HIV or AIDS, and prolonged use of corticosteroids and other immune weakening medications)

☐ The individual has severe obesity (body mass index [BMI] ≥40)

☐ The individual has diabetes

☐ The individual has chronic kidney disease undergoing dialysis

☐ The individual has liver disease

☐ The individual is pregnant and should be monitored since they are known to be at greater risk for severe viral illness

Health Care Provider Signature: _____ Date: _____

Health Care Provider Name: _____

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