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

Employees who are concerned about returning to onsite work because they are a high-risk individual or live with a high-risk individual should complete this form and have the health care provider certification completed (unless their concern is that they are age 65 or older). The final form should be sent to UHRM. UHRM will confirm to the supervisor that the employee is eligible to request a temporary work adjustment. Completing this form is no guarantee that the temporary work adjustment will be approved. Temporary work adjustments must be analyzed by the department and may be approved based on the needs and abilities of the department using fair and objective criteria (with oversight from the cognizant VP).

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 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:

☐ 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: _____

University Human Resource Management

250 East 200 South, Suite 125, Salt Lake City, Utah 84111 Phone: (801) 581-7447

Fax Completed Form to UHRM at: (801) 585-7375

Email Completed Form to UHRM at: AskHR@utah.edu