EMPLOYEE REQUEST FORM FOR REASONABLE ACCOMODATION REGARDING COVID-19 PRECAUTIONS FOR HIGH-RISK INDIVIDUALS AND WEARING FACIAL COVERINGS

Instructions: The following information must be completed if you have a medical condition that places you in a high-risk category should you contract the COVID-19 virus AND/OR if you have a medical condition that contraindicates the wearing of a face mask or covering. The health care provider information must be completed by a qualified health care professional who has made the determination of your medical condition. Please submit the completed form to the Human Resources Office.

Name____Email______________________________

Work Phone__________________________ Home or Cell Phone_____________________________

Direct Supervisor ____

Health Care Provider must complete:

Do you attest that the upon named employee has an underlying health condition places them in a high-risk category? Yes _____ No____

Do you attest that the upon named employee has an underlying health condition that may be compromised by wearing a face mask or covering? Yes _____ No____

Do you have any suggestions regarding possible accommodations or recommendations for an alternative face mask or covering that is allowed by the employee's medical condition?

Yes _____ No____ If yes, what are they?

Health Providers Signature:______________________________________ Date:__________

Employee Signature:____ Date:__________

Director of HR Signature:____ Date: __________