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**CONFIDENTIAL**

**Physician Medical Information Request and Verification Form for**

**Employees at Higher Risk for Severe Illness from COVID-19**

Dear Physician,

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, am an employee at Lehigh University and I have submitted a request for a reasonable accommodation under the Americans with Disabilities Act, as amended. In order to assist with the University’s interactive process, I am requesting that you provide feedback to the following questions about me based on your medical expertise. Please note that the University intends to follow federal, state and local guidance to help contain the spread of COVID-19 (e.g., social distancing, face coverings, cleaning protocols, requiring employees to stay home when sick, etc.).

**Background**

I am seeking verification that, based upon current Centers for Disease Control and Prevention (CDC) guidance (see: <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-at-higher-risk.html>), I am in the category of “people who are at higher risk for severe illness from COVID-19” due to a serious underlying medical condition including people:

* With chronic lung disease or moderate to severe asthma
* Who have serious heart conditions
* Who are 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
* With severe obesity (body mass index [BMI] of 40 or higher)
* With diabetes
* With chronic kidney disease undergoing dialysis
* With liver disease

**Please review the accompanying Position Description and provide your responses to the following:**

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| **Questions to help determine disability and reasonable accommodation** | | | |
| 1. Does the employee have a physical or mental impairment that limits one or more major life activities? | | Yes | No |
| If *yes*, what is the impairment? | | | |
| 1. What adjustments to the work environment or position responsibilities would enable the employee to perform the essential functions of that position (e.g., remote work, flexible work schedule, modified duties, work space modifications, such as barriers, etc.)? Please explain. | | | |
| 1. How long will the employee need the[se] reasonable accommodation[s]? | | | |
| 1. Any additional comments or suggestions: | | | |
| **Signature and Contact Information** | | | |
| Physician Name | Telephone Number | | |
| Address | Email Address | | |
| Physician Signature | Date | | |
| **Please return this form (along with any other additional information that might be useful in processing this accommodation request) to either the employee or to the following Lehigh University office:**  **By email (preferred): incovada@lehigh.edu**  **By regular mail:**  **Office of Human Resources**  **306 S. New Street, Suite 437**  **Bethlehem, PA 18015**  **Tel: (610) 758-3900**  **Fax: (610) 758-6226** | | | |

Attachment(s):

* Position Description