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| **download** | **CONFIDENTIAL REQUEST FOR** **REASONABLE ACCOMMODATION** **FOR EMPLOYEES AT HIGHER RISK FOR SEVERE ILLNESS FROM COVID-19** |

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| **This form is to be completed by the employee** |
| Employee Name | Date of Request |
| Job Title | Department |
| Supervisor Name | Campus Address |
| Please briefly describe your work environment (e.g. private office, cubicle, interaction with visitors, etc.) |
| **Questions related to the accommodation request** |
| 1. Are you in the category of “people who are at higher risk for severe illness from COVID-19” due to a serious underlying medical condition, as defined by the CDC: <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-at-higher-risk.html>
 | Yes | No |
| 1. What specific accommodation(s) are you requesting (e.g., remote work, flexible work schedule, modified duties, work space modifications, such as barriers, etc.)? Please explain.
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| 1. If you are requesting remote work (work from home) as an accommodation, are you able to perform all of your position accountabilities effectively and productively from home?
 | Yes | No |
| If no, what position accountabilities are you unable to perform from home? Are there any reasonable accommodations that would allow you to do so? |
| 1. If you are requesting remote work (work from home) as an accommodation, do you have a work location in your home in which you are able to perform your position accountabilities?
 | Yes | No |

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| 1. If you are requesting remote work (work from home) as an accommodation, have you already discussed your request with your supervisor? **Please note you are not required to disclose any specific health information to your supervisor.**
 | Yes | No |
| 1. Have you submitted the completed Physician Medical Information Request and Verification Form with this document?
 | Yes | No |
| If not, please use your best efforts to do so within 10 calendar days of submitting this request. If your physician is unable to complete the Form in a timely manner, you may be able to submit an alternative form of documentation. Please contact Human Resources at [ ] for additional information. |

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| **Signature****By signing this form, I certify that the information provided in this form is true, complete, and accurate to the best of my knowledge. I acknowledge that I am requesting a reasonable accommodation under the Americans with Disabilities Act, as amended. I agree to cooperate fully with the University in responding to my request, including providing the appropriate medical documentation from my health care provider(s). I agree that I will provide the requested medical documentation in a timely manner. I understand that while the University may not grant the specific accommodation that I have requested, it will engage in good faith efforts to make a determination. I also understand that, in some cases, discussion(s) with my physician may be necessary to address my request for accommodation. In addition, if deemed necessary, the University may request an independent medical evaluation.** |
| Employee Signature | Date |
| **Please return this form along with any other additional information that might be useful in processing this accommodation to the following email address: incovada@lehigh.edu****PLEASE NOTE THAT UPON YOUR COMPLETION AND SUBMISSION OF THIS FORM, ANY REQUESTED ACCOMMODATION IS CONSIDERED TO BE TEMPORARILY GRANTED UNTIL THE UNIVERSITY HAS AN OPPORTUNITY TO REVIEW YOUR MEDICAL DOCUMENTATION AND MEET WITH YOU (VIRTUALLY) TO DISCUSS YOUR REQUEST AND ENGAGE IN THE INTERACTIVE PROCESS.**  |