

COVID-19 TEMPORARY ACCOMMODATION REQUEST FORM

INSTRUCTIONS: If you identify as either 1) at increased risk for serious illness or 2) might be at increased risk for severe illness from COVID-19 and are requesting an accommodation, please use this form to make your request.

Please note that if you are submitting a request because of a medical condition, you will also need your medical provider to complete the Medical Certification Form (form attached).

NAME:	
POSITION:	
WORK SITE:	
EMAIL:	
PHONE:	
SUPERVISOR(s) NAME & PHONE:	

The CDC is regularly updating information on their website regarding underlying medical conditions that are either 1) at increased risk for serious illness or 2) might be at an increased risk for severe illness from COVID-19. A direct link is listed below:

https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fneed-extra-precautions%2Fgroups-at-higher-risk.html

In addition, this link will be added to the ABSS website. Once updated, employees will be able to access the link by selecting District Information → COVID-19 → Employee Information.

1. Do you self-identify as having any underlying medical conditions identified by the CDC as either 1) at increased risk for serious illness or 2) might be at increased risk for severe illness from COVID-19?

YES NO

If yes, please identify the underlying medical condition(s) below:

2. Do you self-identify as having a different medical condition that you believe places you as either 1) at increased risk for serious illness or 2) might be at increased risk for severe illness from COVID-19?

YES NO

If yes, please identify the underlying medical condition(s) below:

Please list your job responsibilities that are impacted by your medical condition that you believe places you as either 1) at increased risk for serious illness or 2) might be at increased risk for severe illness from COVID-19 for which you are requesting an accommodation:

The following are examples of possible accommodations. Please identify which, if any, you are requesting. Some of the accommodations on the list may not be a reasonable accommodation for every position within the school system, and your request will be reviewed in the context of your position and the essential functions affiliated with it. You may also suggest other possible accommodations.

Additional or Enhanced PPE (e.g., cloth face covering, gloves, face shield) Social Distancing Measures (e.g., rearranged workspace) Modified job responsibilities (e.g., temporarily adjust non-essential job functions). Modified work schedule (e.g., staggered shifts) Alternate, on-site, work location (e.g., separate space within the building) Telework
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If needed, please provide more details about your above-requested accommodation:
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Do you have suggestions for any other possible accommodations that will enable you to perform your essential job functions? YES NO

Employee Signature: _____

Date: _____

Medical Provider Certification Form Instructions

If you identify as either 1) at increased risk for serious illness or 2) might be at increased risk for severe illness from COVID-19 because you have an underlying medical condition as defined by the CDC or some other medical condition, you must also submit the attached medical certification form. ***The form must be completed by your healthcare provider. Please submit the completed form and medical certification (if applicable) to:***

Cheryl McKinney (Human Resources Specialist)

- Email: cheryl_mckinney@abss.k12.nc.us
- Fax: 336-570-6075
- Address: 1712 Vaughn Road, Burlington, NC 27217

Medical Provider Certification

To the Provider: The Alamance-Burlington School System's employee named below (your patient) has self-identified as either 1) at increased risk for serious illness or 2) might be at increased risk for severe illness from COVID-19 and is requesting an accommodation. The school system requires further information in order to consider this request.

Patient/Employee Name: _____

1. Does the employee have any underlying medical conditions identified by the CDC as either 1) at increased risk for serious illness or 2) might be at increased risk for serious illness from COVID-19?

YES NO

If yes, please identify the underlying medical condition(s) below:

2. If the employee has a different medical condition that you believe places them as either 1) at increased risk for serious illness or 2) might be at increased risk for severe illness from COVID-19, please identify the condition and address the risk below:

Attestation by Health Care Provider:

Name of Healthcare Provider (Print): _____

Provider's Signature: _____

Practice/Office Name: _____

Office Phone Number: _____ Office Fax: _____

Date: _____

Please submit the completed form and medical certification (if applicable) to:

Cheryl McKinney (Human Resources Specialist)

- Email: cheryl_mckinney@abss.k12.nc.us
- Fax: 336-570-6075
- Address: Alamance-Burlington School System
Attn: Human Resources, Cheryl McKinney
1712 Vaughn Road
Burlington, NC 27217