



1140 Umpqua College Road  
Roseburg, OR 97470

## COVID-19 ACCOMMODATION REQUEST FORM

Part I – To Be Completed by Employee/Applicant Before Providing to Licensed Health Care Provider		
Employee/Applicant Name		Employee #
Position Title	Department	Supervisor/Manager
Email Address	Contact Number <input type="checkbox"/> Home _____ <input type="checkbox"/> Mobile _____	
Employee Signature	Date of Request	
Patient Name (If other than employee):		

Part II – To Be Completed by Licensed Health Care Provider		
Provider's Name	State of Certification or License	License/Certification Number
Type/Practice Specialty	Office Address	Office Telephone Number
<p>Does the patient meet the CDC criteria below for high-risk for severe illness from COVID-19? (Check the boxes for yes or no only, do not circle the diagnosis)</p> <p>People with underlying health conditions such as:</p> <ul style="list-style-type: none"> <li>• Chronic kidney disease</li> <li>• COPD (Chronic Obstructive Pulmonary Disease)</li> <li>• Immunocompromised state</li> <li>• Obesity (BMI of 30 or higher)</li> <li>• Serious heart conditions</li> <li>• Sickle cell disease</li> <li>• Type 2 diabetes mellitus</li> <li>• Asthma (moderate to severe)</li> <li>• Cerebrovascular disease</li> <li>• Hypertension or high blood pressure</li> <li>• Neurologic conditions, such as dementia</li> <li>• Liver disease</li> <li>• Pregnancy</li> <li>• Pulmonary fibrosis</li> <li>• Smoking</li> <li>• Thalassemia</li> <li>• Type 1 diabetes mellitus</li> </ul> <p>Yes <input type="checkbox"/>    No <input type="checkbox"/></p>		

Is it your medical opinion that the patient should self-isolate and/or work remotely due to COVID-19?	
Yes <input type="checkbox"/> No <input type="checkbox"/>	
If the patient is not the employee, it is necessary for the employee to self-isolate or work remotely to prevent exposure of COVID-19 to the patient?	
Yes <input type="checkbox"/> No <input type="checkbox"/>	
If remote work is not operationally or functionally feasible, what alternate reasonable accommodations do you recommend?	
What is the expected duration of the employee/patient's need for such accommodations?	
<b>D. Questions or comments:</b>	
Licensed Health Care Provider's Signature	Date
The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you do not provide any genetic information when responding to this request for medical information. "Genetic information", as defined by GINA, includes an individual's family medical history, the results of an individual's or family members genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.	

Umpqua Community College	Contact: Name: Kelley Plueard	Title: Director, Human Resources	Phone: (541) 440-7690
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Employee/applicant should return this completed and signed form to Human Resources, 1140 Umpqua College Road, Roseburg, OR, 97470. The form can also be emailed to [Kelley.Plueard@umpqua.edu](mailto:Kelley.Plueard@umpqua.edu) or faxed to (541) 440-7712. If faxing this form please call 541-440-7690 to verify receipt.