ADA/FEHA COVID-19 Disability Accommodation Certification

Instructions: Please note, this request form should be utilized for COVID related disability accommodations. Employee/applicant shall contact the treating health care provider to complete this form. Employee/ applicant should return the completed form to ADA coordinator at HSU-HR.

To: ______________________________ Re: ______________________________

Treating Doctor/Health Care Provider — Employee/Patient Name

Treating Health Care Provider: *Please complete the following:*

1. Does your patient have a disability and/or medical condition that makes them "higher risk" as outlined by the Centers for Disease Control (CDC) as it pertains to COVID-19?

☐ Patient ***DOES NOT HAVE*** a disability and/or medical condition that makes them "higher risk" as outlined by the Centers for Disease Control (CDC) as it pertains to COVID-19.

☐ Patient ***DOES HAVE*** a disability and/or medical condition that makes them "higher risk" as outlined by the Centers for Disease Control (CDC) as it pertains to COVID-19. Patient is MEDICALLY RESTRICTED from coming into the workplace, even with PPE employed and social distancing being observed. (Please skip to 1.a. and #2 below and sign, date and return the form).

☐ Patient ***DOES HAVE*** a disability and/or medical condition that medically requires LIMITING their exposure to coronavirus and/or COVID-19, but not "higher risk" as outlined by the Centers for Disease Control (CDC) as it pertains to COVID-19 (Please continue completing the form)

a. PLEASE IDENTIFY ALL APPLICABLE DISABILITY/MEDICAL EMPLOYEE/PATIENT RESTRICTIONS:

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2. **DURATION OF COVID-19 RELATED RESTRICTIONS:** Please confirm the duration of restrictions by checking the appropriate box below:

☐ Restrictions are **TEMPORARY through __________ (date)**

☐ Restrictions are **PERMANENT**

☐ Restrictions are expected to continue as follows (please explain): ________________________

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b. PLEASE IDENTIFY WORKPLACE **<u>RISKS</u>** THAT NEED TO BE ACCOMMODATED OR MITIGATED TO ENSURE A SAFE WORK ENVIRONMENT FOR YOUR PATIENT. WHAT IS IN THE PHYSICAL WORKPLACE THAT IS A MEDICAL RISK FOR YOUR PATIENT:

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c. PLEASE IDENTIFY WORKPLACE **<u>FACTORS</u>** THAT MUST BE PRESENT IN A WORKPLACE TO ENSURE YOU'RE YOUR PATIENT IS SAFE. ***WHAT ACCOMMODATIONS*** NEED TO BE IMPLEMENTED FOR YOUR PATIENT IN ANY WORK ENVIRONMENT THEY WORK IN?

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3. **CURRENT WORK ENVIRONMENT:** HSU will/can implemented the following social distancing and cleaning protocols which meet or exceed OSHA and CDC guidelines for workplace safety:

- Plexiglass separations between the public and employee workstations
- Persons sit no less than 6 feet from each other
- Staffing off-shifting, approximately 50% of the staff are in the office at one time
- Restrooms are cleaned every hour
- Etc.

The above list of safety measures will/can be taken to protect your patient and their colleagues as their work has been deemed mission critical/essential to the business. Are the above measures sufficient to support your patient's to return to the workplace:

☐ YES, the above measures are sufficient to support my patient to return to the workplace.

☐ NO, the above measures are insufficient to support my patient to safely return to the workplace. The following safety precautions also need to be implemented/present:____________

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4. **COMMUTE QUESTION:** Is your patient's request for a work-from-home accommodation related to his/her commute?

☐ NO, the recommendation for an accommodation is NOT related to my patient's commute.

☐ YES, the recommendation for an accommodation IS related to my patient's commute. The commute concern relates to: ☐ he/she uses public transportation or ☐ other, explain: _______

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5. **PERSONAL PROTECTION EQUIPMENT CLARIFICATION**:

   a. Does your patient medical condition require specific personal protection equipment?

☐ NO, Patient's medical condition ***<u>DOES NOT</u>*** require specific personal protection equipment.

☐ YES, Patient's medical condition ***<u>DOES</u>*** require specific personal protection equipment as follows (check all that apply):

- ☐ Medical Mask
- ☐ Respirator with rating greater than: ______________
- ☐ Face Shield
- ☐ Hand Gloves
- ☐ Eye Protection
- ☐ Gowns
- ☐ Aprons
- ☐ Eye Protection
- ☐ Footwear Covers
- ☐ Other: ____

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6. **Additional Restrictions / Accommodation Suggestions**: Please use the space below to include any additional information that you believe would be helpful to the interactive process for this employee. **Please <u>do not</u> list any information pertaining to medical condition or diagnosis.**

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Doctor/Healthcare Provider Print Date

____ __________________________

Doctor/Healthcare Provider Signature License Number

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Healthcare Provider Address

Verified by ADA Coordinator ____ Date: ______________

Revised 08/2020