[Employer letterhead]

Completed form should be transmitted directly by the health care provider to the employer at \_\_\_\_\_\_\_\_\_\_\_\_\_, Attn. \_\_\_\_\_\_\_\_.

**COVID-19 ADA Medical Certification Form for**

**Request for Accommodation For**

**Employee or Family Member Care**

**A. To Be Completed by Employee**:

Employee Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check all that apply:

* I am requesting an accommodation due to my own personal health risk(s) related to COVID-19.
* I am requesting an accommodation because I care for/live with a person considered “high risk” for contracting COVID-19.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Employee: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By signing below, the Employee acknowledges and understands that the Employee must complete the attached **Authorization and Release for Medical Information** for the \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ School District to proceed with considering requested accommodations. The Employee also acknowledges and understands that the District will be contacting the listed Health Care Provider(s) regarding confidential health information of the Employee or Patient regarding any diagnosis, mental condition(s), physical condition(s), illness, injuries, and/or treatment **that is relevant to the employee’s request for accommodations related to COVID-19**, in accordance with the attached Authorization and Release for Medical Information.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee Signature Date

**B. To Be Completed by Employer:**

Employee’s Job Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [**Job Description Attached**]

Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee’s Regular Work Schedule: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Essential Functions of Employee’s Job Affected by COVID-19 Risks (check all that apply):

**NOTE**: The Employer is complying with federal, State and local guidelines regarding social distancing as much as possible, wearing of face coverings, frequent cleaning, etc.

* In-person attendance at work
* Regular face-to-face interaction with students
* Regular face-to-face interaction with the public
* Travel from building to building
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**C. To Be Completed by Health Care Professional and Transmitted Directly to Employer**:

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Care Provider’s Name (please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Care Provider’s Business Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of Practice/Medical Specialty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does Patient have a physical/mental impairment that substantially limits a major life activity? YES / NO

If yes, what is the condition(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Major Life Activities Substantially Limited by Condition(s)(please check all that apply):

|  |  |  |
| --- | --- | --- |
| * Caring for oneself
 | * Performing manual tasks
 | * Seeing
 |
| * Hearing
 | * Eating
 | * Sleeping
 |
| * Walking
 | * Standing
 | * Lifting
 |
| * Bending
 | * Speaking
 | * Breathing
 |
| * Learning
 | * Reading
 | * Concentrating
 |
| * Thinking
* Other – Please Explain:
 | * Communicating
 | * Working
 |

Duration of Condition(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the Patient considered “High Risk” for contracting COVID-19? YES / NO

If yes, please check all that apply to Patient:

|  |  |  |
| --- | --- | --- |
| * Cancer
 | * Chronic Kidney Disease
 | * COPD
 |
| * Immunocompromised state
 | * Obesity
 | * Hypertension or high blood pressure
 |
| * Sickle cell disease
 | * Type 2 Diabetes mellitus
 | * Asthma
 |
| * Cerebrovascular disease
 | * Cystic Fibrosis
 | * Serious heart condition
 |
| * Neurologic condition
 | * Liver disease
 | * Pregnancy
 |
| * Pulmonary fibrosis
 | * Smoking
 | * Thalassemia
 |
| * Type 1 Diabetes mellitus
 | * Other
 |  |

If Other is marked, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If Employee is Patient, would Employee be able to perform the essential functions of his/her job with or without reasonable accommodations? YES / NO

**NOTE**: The Employer is complying with federal, State and local guidelines regarding social distancing as much as possible, wearing of face coverings, frequent cleaning, etc.

If yes, please describe the accommodations you suggest:

|  |  |  |
| --- | --- | --- |
| * Alternative work schedule
 | * PPE (please describe)
 | * Separate workspace
 |
| * Alternative work setting
 | * Plastic/glass partition
 | * Working from home
* Other
 |

Please explain the suggested accommodations for Employee: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If teleworking is unavailable to the Employee, please describe alternative accommodations:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Duration of Suggested Accommodation(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Health Care Provider Date

AUTHORIZATION AND RELEASE FOR MEDICAL INFORMATION

To: The Following Medical Providers of **[PATIENT NAME**](please list):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize you to communicate orally and/or in writing with the following official from the **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_School District** (hereinafter “Recipient”) – **[INSERT DESIGNATED DISTRICT POINT OF CONTACT] –** regarding confidential health information you have or to which you have access concerning any diagnosis, mental condition(s), physical condition(s), illness, injuries, and/or treatment **that creates or presents elevated risk(s) related to the COVID-19 virus and suggested accommodations that would allow me (or my family member employed by Recipient) to perform the essential functions of my (or his/her) job while minimizing the risk of contracting COVID-19**.

I have full knowledge and understand that:

1. By signing the authorization, I am authorizing the release of my confidential health information, **to the extent that such information is relevant to suggesting accommodations to minimize the risk of me or my family member contracting COVID-19**, pursuant to the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) to the above-referenced Recipient.
2. By signing the authorization, I am requesting and allowing the release of my confidential health information to the above-referenced Recipient, **to the extent that such information is relevant to suggesting accommodations to minimize the risk of me or my family member contracting COVID-19**.
3. By signing the authorization, I understand that the specific information to be disclosed in my confidential health information may include information regarding (a) drug and alcohol abuse and/or (b) counseling referrals, **to the extent that such information is relevant to suggesting accommodations to minimize the risk of me or my family member contracting COVID-19**. Moreover, I fully understand that the information is specifically protected by federal regulations including 42 C.F.R. part 2[[1]](#footnote-1) and that by signing the authorization I am allowing the release of information regarding any drug and/or alcohol treatment and/or counseling referrals to the above-referenced Recipient.
4. By signing the Authorization, I understand that there is a potential that information disclosed pursuant to the Authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA, **to the extent that such information is relevant to suggesting accommodations to minimize the risk of me or my family member contracting COVID-19**.
5. I understand that I can revoke the Authorization at any time, except to the extent that action has already been taken in reliance upon it. I understand that any revocation of the Authorization must be in writing and must be addressed to **[INSERT DISTRICT POINT OF CONTACT LISTED ABOVE]**.
6. The authorization expires one year after it is signed.

I hold the above-named institution harmless from any and all damages which might result to me and/or to my relatives or heirs from the use of the information’s being disclosed to the Recipient.

**The authorization is continuing in nature and is to be given full force and effect to release any and all of the foregoing information learned or determined after the date hereof. A copy of the release shall be considered to have the same authority vested in an original.**

**INFORMATION IS TO BE RESTRICTED TO THE FOLLOWING PATIENT:**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Social Security No.**

**Date of Birth:**

**Check One: Present Patient Former Patient**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature Date**

STATE OF MISSOURI )

 ) SS

COUNTY OF \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ )

Subscribed and sworn to before me the \_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 2020.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Notary Public

My Commission Expires: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. *THE FOLLOWING APPLIES ONLY TO DRUG AND/OR ALCOHOL ABUSE/TREATMENT INFORMATION published on Re-disclosure: The information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR part 2) prohibit you from making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for the purpose.* [↑](#footnote-ref-1)