NORTHWESTERN STATE

Alternate Work Accommodation Request Form

Employees requesting alternative work accommodations due to COVID-19 must complete the form and submit, with designated supporting documentation, to the Human Resources COVID-19 email box at covid19hr@nsula.edu

Employee Name:	Employee ID#
Employee Job Title:	Employee Department:
Employee Phone #:	Employee E-mail:
Supervisor Name:	Supervisor E-mail:

VOLUNTARY DISCLOSURE OF HEIGHTENED RISK OR ACCOMMODATION NEED

I am requesting an alternative work accommodation for the following reason:

☐ 1. I am at greater risk for severe illness from COVID-19 due to my age. Age: _____

☐ 2. I have an underlying medical condition recognized by the CDC. (Describe below)

☐ 3. I am caring for or share a household with an individual who, due to age or an underlying medical condition, is at greater risk of severe illness from COVID-19.

Relationship to Individual: _____ Age: _____ Condition: (Describe below)

☐ 4. Other specific circumstances not covered above (list only circumstances that can be effectively evaluated through supporting documentation, such as child care needs):

_____

Please describe what underlying medical condition puts you (or someone you are caring for or share a household with) at a greater risk for severe illness from COVID-19.

For options 1, 2, or 3, **please attach documentation from a medical provider** that supports the basis for your request. Documentation is not required if the condition is known or obvious to the University. Documentation must be typed on office or practice letterhead and signed by a professional who is licensed or certified in the area for which the diagnosis is made.

REQUESTED/SUGGESTED ALTERNATIVE WORK ACCOMMODATION

Select the specific alternative work accommodation you requesting.

☐ Modification of work schedule (telework, flexible scheduling, reduction of hours, hybrid, etc.)

☐ Modification of physical environment (plexiglass guard, alternative on-site work location, etc.)

☐ Other workplace accommodation

Please describe the specific request based on the selection above and how you expect this accommodation to effectively assist you to perform the essential functions of your position.

Duration requested (not to exceed one semester):

EMPLOYEE CERTIFICATION

When requesting the alternative work accommodation, I agree that to the best of my knowledge, the information I provided is truthful and accurate. I understand that any willful misrepresentation or falsification may lead to ineligibility for these benefits and may be cause for disciplinary action. I agree to provide additional documentation if needed. I understand each request is considered within the context of submitted documentation, job requirements, and available resources and that I may not be provided the specific accommodation I have requested. I agree that if I fail to perform my essential duties and responsibilities, the alternative work accommodation may be revoked.

Employee Signature: _____ Date: _____

Supervisor's Approval of Request & Notes __ Yes No

Supervisor's signature: _____ Date: _____

HUMAN RESOURCES USE ONLY

Required documentation (if applicable) received from the employee: **Yes** **No**

Alternative Work Arrangement Decision: ☐ Approved ☐ Denied ☐ Modified (see below)

Modifications:

ROUTING PROCESS FOR APPROVAL

	Approved	**Not Approved**	**Pending**
Human Resources	_____	_____	_____
Direct Supervisor	_____	_____	_____
Department /Unit Head (if applicable)	_____	_____	_____
Vice President	_____	_____	_____

EMPLOYEE AUTHORIZATION and PHYSICIAN CONTACT INFORMATION: The physician may receive communication form the institution on your impairment/disability and recommendations for alternative work accommodations.

I authorize a representative of Human Resources to communicate directly with my health care provider for confirmation of my underlying health condition and, if needed, clarification regarding my need for an alternative work accommodation.

Employee Signature: _____ Date: _____

Physician's Name:	Physician's E-mail:
Physician's Phone #:	Physician's Fax #:
Physician's Address:	

PHYSICIAN CERTIFICATION (Not required if the underlying health condition is known or obvious)

Does the employee have an underlying medical condition that presents a greater risk of severe illness for COVID-19? **Yes** **No**

If yes, what is the underlying medical condition(s)?

Describe relevant medical facts related to the condition(s) for which the employee is seeking alternative work accommodations.

Estimate the beginning and ending dates for the period of alternative work accommodations.

Physician Signature: _____ Date: _____