EWU COVID Alternate Work Arrangement Plan
For High Risk Employees

This form is to be used by employees who identify as "high risk" as defined by the Center for Disease Control which includes having one or more of the following conditions: cancer; cerebrovascular disease; chronic kidney disease; COPD; diabetes mellitus, type 1 or type 2; heart conditions (such as heart failure, coronary artery disease, or cardiomyopathies); smoking; obesity, down syndrome, HIV, neurologic conditions; overweight; other lung disease (including interstitial lung disease, pulmonary fibrosis, pulmonary hypertension); sickle cell disease; (including interstitial lung disease, pulmonary fibrosis, pulmonary hypertension); substance use disorder; use of corticosteroids or other immunosuppressive medications; cystic fibrosis; thalassemia; asthma; hypertension; liver disease; pregnancy; and/or immune deficiencies **This form must include certification from a health care provider regarding high risk status to include consideration of vaccination status.**

Last Name	**First Name**	**Middle Initial**	**EWU ID Number**

Position Title	**Position Is Overtime:** ☐ Eligible ☐ Exempt	**Position Number**

Effective Begin Date: (*Must be effective on a Monday)*	**Effective End Date**:

Describe the Alternate Work arrangement requested:

_____

_____

If the plan includes a request for modification of an on campus work location, please identify the requested modification: (e.g. installation of a plexi-glass barrier, additional PPE)

_____

_____

Date	Employee Acknowledgement:	

Submit this EWU COVID Alternate Work Arrangement Plan For High Risk Employees to Human Resources and the accompanying medical certification to Showalter Hall, Room 314; Mail Code SHW 314; or hr@ewu.edu. Human Resources will coordinate the processing of the request for a COVID Alternate Work Arrangment Plan, including facilitating an interactive process with the employee and their supervisor to determine an appropriate accommodation.

Agreed Upon COVID Alternate Work Arrangement Plan for High Risk Employee:

_____

_____

Approval/Acknowledgment:

Date	Employee Acknowledgement:	Date	Supervisor approval: ☐ **Yes** ☐ **No**
Date	2nd Level Supervisor: ☐ **Yes** ☐ **No**	Date	Other Supervisor approval: ☐ **Yes** ☐ **No**
Date	Vice President or equivalent ☐ **Approval** or ☐ **Denial** (If denied, please send a statement for denial with form to HR)		
Comments:			
Date Reviewed by HR:	Signature:		

Distribution of Approvals:

- ☐ Original to Personnel File (HR, SHW 314)
- ☐ Supervisor
- ☐ Employee
- ☐ Purchasing (for equipment used outside of campus_
- ☐ Environmental Health and Safety (for telework)

Distribution of Denials:

- ☐ Original to Personnel File (HR, SHW 314)
- ☐ Vice President
- ☐ Supervisor
- ☐ Employee

Medical Certification Form
High Risk Employees Seeking an EWU COVID Alternate Work Arrangement Plan and Employee Consent to Release Confidential Information

Patient Name:_____ Date: _____

I am a licensed health care provider currently treating the above-named patient. I am aware that the Centers for Disease Control (CDC) have identified persons with the following conditions as high-risk for COVID-19:

> Cancer; cerebrovascular disease; chronic kidney disease; COPD; diabetes mellitus, type 1 or type 2; heart conditions (such as heart failure, coronary artery disease, or cardiomyopathies); smoking; obesity, down syndrome, HIV, neurologic conditions; overweight; other lung disease (including interstitial lung disease, pulmonary fibrosis, pulmonary hypertension); sickle cell disease; (including interstitial lung disease, pulmonary fibrosis, pulmonary hypertension); substance use disorder; use of corticosteroids or other immunosuppressive medications; cystic fibrosis; thalassemia; asthma; hypertension; liver disease; pregnancy, and/or immune deficiencies

I certify that the above-named patient, has one or more of the conditions identified by the CDC as placing individuals at high-risk. Considering the above-named patient's medical condition, vaccination status and particular circumstances of their job, the following accommodations are recommended:

- Workplace accommodations:_____

_____

_____

- Alternative workplace accommodations: _____

_____

_____

_____

Print Name **Date**

_____

Signature

_____

Address

_____

Phone Number

EMPLOYEE CONSENT TO RELEASE CONFIDENTIAL INFORMATION RELATED TO REQUEST FOR COVID-19 ALTERNATE WORK ARRANGEMENT PLAN

The Purpose of this Disclosure of Information is to determine eligibility for a reasonable Eastern Washington University COVID-19 Alternate Work Arrangement Plan

Name of Employee: _____ Date of Birth: _____

Job Title: _____ Department: _____

Work Schedule: _____

Name of Health Care Provider: _____

Health Care Provider Address: _____
Street City State Zip

Health Care Provider Phone: _____

I hereby authorize the above listed health care provider and any others who have treated me to release to Eastern Washington University the following information related to my health care: diagnosis of relevant condition(s), the severity and duration of the impairment, my ability to perform my work with or without reasonable accommodation, and information as to why the requested reasonable accommodation is needed. I also authorize disclosure and discussion as necessary so that EWU may determine appropriate and reasonable accommodations for me. I understand that information obtained under this release is a confidential medical record and is maintained separately from my personnel file. This authorization is valid for a period of ninety (90) days after signature.

I further understand that, if I have a qualifying disability, EWU is not obligated to provide any specific accommodation I request, but will evaluate all information gathered through an interactive process with me and otherwise to make a determination of what is a reasonable accommodation regarding an Eastern Washington University COVID-19 Alternate Work Arrangement Plan.

Employee Signature: _____ Date: _____