Employee Request for COVID-19 High Risk Exemption

Last Name:	**First Name:**	
Personnel #:	**Job Title:**	**Request Date:**
Office/Division: Select One	**Supervisor:**	

Step 1: EMPLOYEE COMPLETES AND ROUTES TO IMMEDIATE SUPERVISOR

By typing my initials below, I hereby acknowledge the following:

_____ *I am at a higher risk of severe illness from COVID-1, and I am requesting a COVID-19 high risk exemption due to my age. (65 years or older).*

_____ *I am at a higher risk of severe illness from COVID-1, and I am requesting a COVID-19 high risk exemption due to an underlying medical condition as identified by the CDC/Governor's Proclamations.*

_____ *I acknowledge that if my request is due to an underlying medical condition that I must provide a medical certification form that is completed by my health care provider within 10 business days of the submission of this form to my supervisor.*

_____ *I understand that once this form is signed by my supervisor, I am authorized to work from home for up to 10 business days while I obtain medical certification from a health care provider and review by LDOE HR and Legal. After 10 business days I must either return to my primary work site or take leave in order of sick, compensatory/annual, then LWOP.*

_____ *I understand that if my request is approved that I must obtain an approved Telecommuting Work Agreement in accordance with LDOE Policy No. EP 2.21 – Telecommuting.*

_____ *I understand that if my request is denied that I must report to my primary work site.*

_____ *I understand that all employees, including those with higher risk, will eventually be required to return to their primary work site upon order of the State Superintendent.*

_____ *I certify that I have read and understand the COVID-19 High Risk Exemption Guidance.*

Step 2: IMMEDIATE SUPERVISOR COMPLETES AND ROUTES TO HUMAN RESOURCES

Certification: *By typing my name and initials below, I acknowledge that this employee is requesting a COVID-19 high risk exemption and may telecommute for up to 10 business days while he/she obtains a medical certification from a health care provider and review by LDOE HR.*

_____ _____ _____

Immediate Supervisor Printed Name ***Initial to Certify*** ***Date***

For Human Resources ONLY

Date Request Received: _____ **Request Reviewed by: _____**

☐ **Approved** ☐ **Denied**

Date Employee Notified: _____ **Date Supervisor Notified: _____**

Please select all applicable items received for this employee's request:

☐ Medical Certification for COVID-19 High Risk Exemption

Date Sent to Employee: _____ Date Received: _____

☐ Approved Telecommuting Agreement on file with Human Resources

☐ Copy of employee and supervisor notification