FORDHAM
THE JESUIT UNIVERSITY OF NEW YORK | Office of Human Resources Management

COVID-19 Temporary Accommodation Request
Employee's Household Member or Family Member Cared for by Employee
Medical Form

SECTION 1 :TO BE COMPLETED BY EMPLOYEE

Employer Name: Fordham University - 441 E. Fordham Road - Bronx, NY 10418

Contact: Office of Human Resources Management and Occupational Health Consultant

Email Forms to **occ-health-medicine@fordham.edu**

NOTE: Please visit **Fordham's Email Encryption website** and follow the process to safeguard and ensure the privacy of your medical information.

Employee's Name:

_____

First Middle Last

Name of household member, or family member for whom you provide care :

_____

First Middle Last

Relationship of family member to you:

_____

Describe care you will provide to your family member, frequency, setting:

_____

_____

_____

_____

_____

_____

Employee's Signature

SECTION 2: TO BE COMPLETED BY HEALTH CARE PROVIDER

I**NSTRUCTIONS to the HEALTH CARE PROVIDER**: The employee listed above has requested an accommodation because they live with or must care for your patient. Answer, fully and completely, all applicable parts below. Please be sure to sign the form on the last page.

Provider's name and business address:

_____

_____

Type of Practice / Medical Specialty:

_____

Telephone: (_____)_____

Fax:(_____)_____

MEDICAL FACTS RELATED TO TEMPORARY COVID-19 ACCOMMODATION REQUEST

Please identify your patient's medical condition(s) from the **CDC High Risk Categories and People Who Need to Take Extra Precautions** for COVID-19 that apply, and specify if you are the patient's medical provider regarding the condition(s).

☐ HIV or other immunocompromising condition	☐ Medical Provider
☐ Asthma (moderate-to-severe)	☐ Medical Provider
☐ Chronic lung disease	☐ Medical Provider
☐ Diabetes	☐ Medical Provider
☐ Serious heart condition	☐ Medical Provider
☐ Chronic kidney disease	☐ Medical Provider
☐ Severe obesity	☐ Medical Provider
☐ Other	☐ Medical Provider

If other, please specify the medical condition per the **CDC High Risk Categories and People Who Need to Take Extra Precautions** for COVID-19:

_____

If you are the Medical Provider for the condition listed, please attach relevant medical history, including diagnosis, dates of hospitalizations, tests, etc.

ADDITIONAL INFORMATION/NOTES REGARDING YOUR PATIENT'S RISK FACTORS FOR COVID-19:

Identify the accommodation that you are recommending for the employee in order to reduce risk to your patient:

Identify other possible accommodations that you believe would be acceptable to minimize risks to your patient, relative to the employee, such as increased distancing from others, barriers, appropriate additional PPE, etc.

Signature of Health Care Provider **Date**

_____

Medical License Number

GINA Statement to Health Care Provider: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, the **Fordham University Office of Human Resources Management and/or the University's Occupational Health Consultant** at my employer are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.