COVID-19-Based Arrangements/Modification Request Form

Instructions:
1. Employee must complete pages 1 and 2
2. Employee must have their physician complete pages 3 and 4
3. Employee must return all completed pages (1-4) along with supporting documents to:

Bill Wolfe
LSUS Office of Human Resource Management
AD 109
bill.wolfe@lsus.edu

NOTE: Accommodations will be considered based on information provided AND the employee's demonstrated ability to perform their job duties in a remote capacity. Accommodations are granted for the safety of the employee. Accommodation requests made due to age or family care will not be considered at this time.

Employee Name_____________________ LSUS E-mail___________________________

Phone Number_____________________________ Job Title_______________________

Department______________________________ Regular Work Hours_____________

Immediate Supervisor _____________________ Department Head __________________

I am seeking to:

☐ Teach/work synchronously remotely from a non-campus location

☐ Teach/work synchronously but virtually from a campus facility (without students in the physical classroom)

☐ Other (please specify accommodations/modifications sought)

____

____

Duration of request for accommodations/modifications

☐ Present through Fall Semester 2021

☐ Other (please specify and provide rationale)

____

____

☐ I have been vaccinated for COVID

☐ I have not been vaccinated for COVID due to personal or medical exemption

Rationale to support request for accommodations/modifications:

____

____

Rationale to explain why existing workplace accommodations/modifications are insufficient:

____

____

EMPLOYEE MUST ALSO HAVE HEALTHCARE PROVIDER COMPLETE THE MEDICAL PROVIDER'S CERTIFICATION ON PAGES 3 AND 4 OF THIS FORM

Consent for Release of Information: I, ______________________________ hereby consent for the LSUS Office of Human Resource Management to internally share pertinent information with necessary university personnel for the sole purpose of determining eligibility and implementation of any accommodations/modifications requested or deemed necessary.

EMPLOYEE SIGNATURE ______________________________ DATE __________________

LSU Shreveport COVID Accommodation Request – Provider's Certification

Employee Name ______________________________________

INSTRUCTIONS FOR HEALTHCARE PROVIDER:

LSUS has implemented the following protective measures to operate safely on campus during the Covid-19 pandemic:

- Masks are mandatory indoors for all
- Social distancing is required
- Classrooms and offices are modified with screens and Plexiglass
- Enhanced cleaning protocols are in place
- Mandatory quarantine and isolation protocols are in place

PLEASE COMPLETE THE FOLLOWING AS RELATED TO THE ABOVE EMPLOYEE:

The mitigation measures above are satisfactory (check one)

☐ YES
☐ NO

If you checked NO, please describe why an accommodation is recommended, what the recommended accommodation should be, and why LSUS current protective measures do not suffice for this employee (attach additional pages if necessary).

____

____

____

____

Has this employee been medically advised not to receive the COVID vaccination?

☐ YES
☐ NO

Name of Healthcare Provider:

____

Address:

____

____

____

PHYSICIAN'S SIGNATURE __________________________________ DATE ___________

Completed form must be returned to employee for submission to LSUS Office of Human Resource Management