



## COVID-19 CERTIFICATION OF HEALTHCARE PRACTITIONER FORM

<b>Part I – To Be Completed by Employee Before Providing to Medical Provider</b>																											
Date of Request:	Employee Name:	Employee SOU ID Number: 940-																									
Position Title:	Department:	Supervisor/Manager Name:																									
Email Address:	Contact Numbers Home: _____ Mobile: _____																										
Patient Name (If other than employee):		Relationship:																									
Employee Signature:																											
<b>Part II – To Be Completed by Medical Provider</b>																											
Physician's Name:	State of Certification or License:	License/Certification Number:																									
Type/Practice Specialty:	Office Address:	Office Telephone Number:																									
<p>This is reviewed as a request for disability accommodation under the Americans with Disabilities Act, as Amended (ADA). The term disability is defined broadly under the ADA and includes individuals who:</p> <ul style="list-style-type: none"> <li>Currently have a physical or mental impairment that substantially limits one or more major life activities; or</li> <li>Have a record of, and are still impacted by, such an impairment.</li> </ul>																											
<p>1. Does the patient's underlying medical condition(s) constitute a disability as defined above? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please select all life activities that are affected by the employee/applicants impairment:</p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Bending</td> <td><input type="checkbox"/> Hearing</td> <td><input type="checkbox"/> Reaching</td> <td><input type="checkbox"/> Standing</td> </tr> <tr> <td><input type="checkbox"/> Breathing</td> <td><input type="checkbox"/> Interacting with Others</td> <td><input type="checkbox"/> Reading</td> <td><input type="checkbox"/> Thinking</td> </tr> <tr> <td><input type="checkbox"/> Caring for Self</td> <td><input type="checkbox"/> Learning</td> <td><input type="checkbox"/> Seeing</td> <td><input type="checkbox"/> Walking</td> </tr> <tr> <td><input type="checkbox"/> Concentrating</td> <td><input type="checkbox"/> Lifting</td> <td><input type="checkbox"/> Sitting</td> <td><input type="checkbox"/> Working</td> </tr> <tr> <td><input type="checkbox"/> Eating</td> <td><input type="checkbox"/> Operation of a major bodily function</td> <td><input type="checkbox"/> Sleeping</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Performing Manual Tasks</td> <td><input type="checkbox"/> Speaking</td> <td></td> </tr> </table>				<input type="checkbox"/> Bending	<input type="checkbox"/> Hearing	<input type="checkbox"/> Reaching	<input type="checkbox"/> Standing	<input type="checkbox"/> Breathing	<input type="checkbox"/> Interacting with Others	<input type="checkbox"/> Reading	<input type="checkbox"/> Thinking	<input type="checkbox"/> Caring for Self	<input type="checkbox"/> Learning	<input type="checkbox"/> Seeing	<input type="checkbox"/> Walking	<input type="checkbox"/> Concentrating	<input type="checkbox"/> Lifting	<input type="checkbox"/> Sitting	<input type="checkbox"/> Working	<input type="checkbox"/> Eating	<input type="checkbox"/> Operation of a major bodily function	<input type="checkbox"/> Sleeping	<input type="checkbox"/> Other _____		<input type="checkbox"/> Performing Manual Tasks	<input type="checkbox"/> Speaking	
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<p>2. Does the patient have an underlying medical condition(s) that makes them more susceptible to serious illness from COVID-19? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>																											
<p>3. If the patient is not the employee, it is necessary for the employee to self-isolate, work remotely, or take other precautions to prevent exposure of COVID-19 to the patient? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>																											
<p>4. If the patient is the employee, what suggestions do you have regarding possible reasonable accommodations that will permit the employee to safely and satisfactorily perform their job duties?</p>																											
<p>5. If remote work was suggested, and should the university deem it not operationally or functionally feasible, do you have any alternative suggestions for reasonable accommodation for the university to consider?</p>																											

6. What is the expected duration of the employee/patient's need for such accommodation(s)?	
Effective Date:	End Date:
Medical Provider's Signature:	Date:
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, we are asking that you do 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 members 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.	

Please return this completed and signed form to [HRS@sou.edu](mailto:HRS@sou.edu), fax (541) 552-8508, or by mail at the following address:

Southern Oregon University  
 Human Resource Services  
 Churchill Hall, Room 159  
 1250 Siskiyou Boulevard  
 Ashland OR, 97520.

Please direct all questions to Michele Barlow, Assistant Director of Human Resources/Accessibility Coordinator, [barlowm@sou.edu](mailto:barlowm@sou.edu) or (541) 552-8119.