THE UNIVERSITY OF ALABAMA

Medical Provider Inquiry Form for COVID-19 Accommodation Request

This form must be completed by the medical provider.

Direct questions to HR Service Center at (205)-348-7732 or hrsvctr@ua.edu.

Employee Name: _____ **CWID:** _____

Phone: _____ **Email:** _____

Employee Signature: _____ **Date:** _____

I have voluntarily completed this COVID-19 Accommodation Request Form and all information provided is complete, true, accurate, and not misleading. I give The University of Alabama permission to speak to my health care professional and I acknowledge that such communication is job-related and consistent with business necessity. I understand that all information obtained will remain confidential and maintained by Human Resources.

According to the Centers for Disease Control and Prevention, people of any age who have certain underlying medical conditions are members of a '**vulnerable population**' that are or might be at increased risk for severe illness from COVID-19. Your answers to the following questions will help determine if an employee is in the vulnerable population and/or if the employee shares a household with or has primary caregiving responsibility for a family member who is in the vulnerable population.* (CDC List)

1. Eligible Individual in Vulnerable Population (check one): ☐ Employee ☐ Family Member

2. If employee shares a household and/or is primary caregiver for a family member, please provide the following:

Family Member Full Name: _____ Date of Birth: _____

Relationship to Employee (check one): ☐ Spouse/Partner ☐ Child ☐ Parent

3. Does the eligible individual have any of the conditions listed on the CDC website? ☐ Yes ☐ No

4. What specific medical condition(s) does the eligible individual have? List all qualifying conditions.

_____

_____

_____

5. Explain how the above listed medical condition(s) cause the eligible individual to be at increased risk for severe illness from COVID-19.

_____

_____

_____

6. If the eligible individual is an employee, do you have any suggestions regarding possible accommodations that would reasonably enable the employee to perform their job at the workplace (i.e., increased distancing from others, physical barriers, specific PPE, etc.)? If so, what are your suggestions?

_____

_____

_____

7. Other Comments:

_____

_____

_____

8. Medical Provider Information: *Please print the following information as clearly and legibly as possible.*

Medical Provider Name: _____

Name of Medical Practice: _____

Medical Provider Alabama License # and/or NPI: _____

Mailing Address: _____

City, State, Zip Code: _____ Telephone: _____

Medical Provider's Signature: _____ Date: _____

Please return completed medical inquiry forms to:

The University of Alabama
Attn: COVID-19 Accommodations
Box 870174
Tuscaloosa, AL 35487

Fax: 205-348-8755 | **Email:** hrsvctr@ua.edu

A secure drop box is also available outside the HR Administration Building located at 1670 Ruby Tyler Parkway, Tuscaloosa, AL 35487. The employee may choose any method to return the completed form to Human Resources.

** 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 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.*