Plano ISD

Medical Certification Form for Employees in COVID-19 High Risk Category

To be completed by the medical practitioner:

The employee listed below has identified himself/herself as your patient and has indicated that he or she is in a category identified by the Centers for Disease Control (CDC) as high risk for severe illness in contracting the COVID-19 virus due to an underlying medical condition. The employee has requested modifications to the work environment and/or job functions as a direct result of and for the duration of the COVID-19 health pandemic. Your assistance is appreciated in providing information to determine appropriate personal protective equipment (PPE), work environment modifications, or specific job functions to mitigate his or her risk of contracting the COVID-19 virus. The employee named below has completed the attached request and consent for your reference.

Patient Name: _____ DOB: _____

Job Title: _____

1. Does this individual have an underlying health condition which places them at higher risk of severe illness in contracting the COVID-19 virus, as defined by the CDC? _____ No _____ Yes

2. If yes, please indicate the type of underlying health condition:

_____

_____

_____

_____

3. Describe the PPE, work environment or job duty modification(s) that are required for the employee to mitigate his or her risk in the workplace with respect to the COVID-19 virus.

_____

_____

_____

_____

_____

_____

4. Are the modification(s) required solely for the purpose and duration of the COVID-19 health pandemic? _____ Yes _____ No (Explain)

_____

_____

_____

5. What is the duration or expected duration of the required modifications?

_____

_____

6. Does this individual's health condition substantially limit any major life activities, as defined by the ADA/ADAAA? _____ No _____ Yes (Explain)*

_____

_____

_____

* If yes, please provide additional details to support a disability accommodation. As defined by the ADAAA, major life activities include, but are not limited to: caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working. For more information, visit https://www.dol.gov/ofccp/regs/compliance/faqs/ADAfaqs.htm

Name of Medical Practitioner: _____

Phone: _____

Medical Practitioner's Signature: _____

Date: _____

Please return the completed form to Benefits@pisd.edu or mail to:

Plano Independent School District
Benefits & Risk Management Department
Attn: Nikki James/Megan Schuler
6301 Chapel Hill Blvd
Plano, TX 75093