Plano ISD

Work Modification Request Form – Due to COVID-19

This form is an initial step in gathering information for review of a request for work modification due to COVID-19. Please provide as much detail as possible to assist the District in the review process. The PISD Benefits Department will facilitate gathering information, and may require additional information from you, including a medical certification from your medical provider(s).

To be completed by the employee

Employee Name: ____

ID #: __________________________

Job Title: ____

School/Department: ____

Supervisor Name: ____

1. What situation is prompting your request for work modification: (indicate all that apply)

   ☐ I have a medical condition where I **am at increased risk** of severe illness from COVID-19 (medical certification will be required)

   ☐ I have a medical condition where I **might be at increased risk** of severe illness from COVID-19 (medical certification will be required)

   > These categories are defined by the CDC. To correctly identify which one applies to you, please review the lists of medical conditions on the CDC's web site at www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html

   ☐ I am pregnant

   ☐ Normal pregnancy ☐ High-risk pregnancy

   Due Date: ___________________

   ☐ There are high-risk individuals living in my household.

   ☐ My children will be doing school from home.

   ☐ Other

   Please provide any additional details for consideration:

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2. Describe the modification(s) that you are requesting for your work environment or job duties, and the specific problems that the requested modification(s) will address.

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3. Describe any personal protective equipment (PPE), other protective measures or resources which would address your situation.

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

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5. What is the expected duration that you would require the requested modification(s)?

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If this request is related to the employee's medical condition:

Name of Employee's Medical Provider: ____

Address: ____

Phone: __________________________________

Email: ___________________________________

My signature confirms my request as described above, and I understand that additional information may be required. If my request is related to my own medical condition, my signature indicates my permission for Plano ISD to contact my medical provider to seek additional or clarifying information and for the medical provider to release such information as applicable in evaluating my request. The information

provided is true and correct to the best of my knowledge. If seeking additional information or clarification from your medical provider, a copy of this request will be provided to the medical provider named above.

Employee Signature: ____ Date: ________________

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

Plano ISD
Benefits & Risk Management Department
6301 Chapel Hill Blvd
Plano, TX 75093