COVID-19 Workplace Accommodation Medical Certification

Section I: Authorization for Release of Information

Employee Name _____ **Job Title** _____

I hereby authorize the release of the following information to University of Northern Iowa Human Resource Services (HRS) for the purpose of determining the availability of reasonable workplace accommodations due to the COVID-19 pandemic. I further authorize HRS to seek clarification, if necessary, by contacting the healthcare provider completing this certification.

Signature _____ **University ID** _____ **Date** _____

Section II: Healthcare Provider Instructions & Certification

Your patient has requested a workplace accommodation due to the COVID-19 pandemic. To facilitate your patient's request for accommodation, we need you to complete this medical certification regarding whether your patient, due to a pre-existing disability or medical condition, needs a workplace accommodation during the COVID-19 pandemic. Your prompt response to the questions below is appreciated.

To comply with The Genetic Information Nondiscrimination Act of 2008 (GINA), please do not provide any genetic information when responding to this request for medical information. "Genetic Information" includes and individuals 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.

1. Does the employee have an underlying disability or medical condition for which the employee needs an accommodation due to the COVID-19 pandemic? ☐ **Yes** ☐ **No**

If **Yes**, please describe the underlying disability or medical condition and explain why this disability/medical condition necessitates a workplace accommodation due to COVID-19.

2. What, if any, suggestions do you have regarding possible accommodations that would enable the employee to perform the essential functions of their position during the COVID-19 pandemic?

Healthcare Provider Name (please print): _____

Type of Practice/Specialty: _____ Phone: _____

Address: _____

Healthcare Provider Signature: _____ Date: _____

Please return completed form via fax to UNI Human Resource Services at 319.273.2430