COVID-19 Alternate Work Arrangement Request Form

In addition to accommodations provided in accordance with the ADA, Transylvania University provides alternative work arrangements for employees in response to public health emergency guidance when it will enable the performance of the employee's essential functions and when doing so does not create an undue hardship to the university.

Employees who are requesting alternative work arrangements must complete and submit this request form along with designated supporting documentation to human resources at hr@transy.edu

- A confidential discussion with human resources is encouraged for employees who are seeking reasonable accommodations.
- If more information is needed, the university may request that you ask your health care provider to confirm your disability and/or the need for the requested alternative work arrangements.
- It is your responsibility to ensure that your health care provider statement or other supporting documentation is returned to human resources.
- You are not required to disclose personal health information to your immediate supervisor regarding the medical basis for a requested alternative work arrangement. Medical records are confidential and maintained in the human resources office only.

Submit all completed forms to hr@transy.edu.

EMPLOYEE INFORMATION	
Employee Name:	Employee ID #:
Employee Job Title:	Employee Department:
Employee Phone Number:	E-mail:
Immediate Supervisor Name:	Supervisor E-mail:
Cabinet Member (if different from immediate supervisor):	
VOLUNTARY DISCLOSURE OF HEIGHTENED RISK: What CDC/Kentucky Department of Public Health circumstance or underlying medical condition puts you at a greater risk for severe illness from the public health emergency?	
REQUESTED/SUGGESTED ALTERNATIVE WORK ARRANGEMENTS This is a *(choose one)*: ☐ New request for alternative work arrangement ☐ Request for an extension and/or alteration of existing accommodations.	

TRANSYLVANIA UNIVERSITY

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What specific alternative work arrangements are you requesting? Please select from the options below:

- ☐ Modification of job duties (provide additional details in the Job Duties and Essential Function section below).
- ☐ Modification of work schedule (telework, flexible scheduling, reduction of hours, etc.).
- ☐ Modification of physical environment (i.e. plexiglass guard, alternative on-site work location).
- ☐ Leave of absence.
- ☐ Classroom Reassignment

If the request is other than modification of job duties, please describe specific request based on the selection above:

Duration requested: until end of public health emergency per CDC/KDPH or until _____(date)

JOB DUTIES and ESSENTIAL FUNCTIONS

Please describe each of your primary job duties (your direct supervisor will be contacted for the essential functions of your job):

Which of your duties do you perceive could be performed with alternative work arrangements, and how?

JUSTIFICATION NARRATIVE

Please describe how the alternative work arrangements requested above will allow you to perform the essential functions of your position (attach separate sheet if necessary):

CERTIFICATION of HEALTH CARE PROVIDER

☐ Health Care Provider Statement (Provider documentation of CDC/KDPH recognized circumstance or underlying health condition together with alternative work arrangements suggestions.

☐ Other Supporting Documentation (Record of diagnosis or other supporting documents that meet public health emergency guidance)

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HEALTH CARE PROVIDER CONTACT INFORMATION: The physician may receive communication from the institution HR requesting information on your impairment/disability and recommendations for alternative work arrangements. (if request is for health reasons)

Name: Telephone #: Fax:	Email Address: Address:

EMPLOYEE AUTHORIZATION

☐ I authorize a representative of the human resources office to communicate directly with my health care provider for confirmation of the CDC/KDPH recognized circumstance or underlying health condition and clarification regarding my need for an alternative work arrangement.

Employee Signature: _____ Date: _____

EMPLOYEE CERTIFICATION

I certify that the above information is accurate and complete. I understand that I must contact the human resources office regarding any changes or deviations to this request once submitted.

Employee Signature _____ Date _____

HUMAN RESOURCES USE ONLY

Required documentation (if applicable) received from employee: No ☐ Yes ☐

Received on date:

Alternative Work Arrangement Decision: ☐ Approved ☐ Denied ☐ Modified as outlined below:

Notes:

Cabinet Signature (if required):

President Signature (if required):