

REQUEST FOR TEMPORARY WORK ADJUSTMENT RELATED TO COVID-19

Employees who are concerned about returning to onsite work because they are a high-risk individual, live with a high-risk individual, or have another COVID-related reason should complete this form. The fully signed form should be sent to OWU Human Resources. Human Resources will confirm with the supervisor that the employee is eligible to request a Temporary Work Adjustment (TWA). Completing this form is no guarantee that the temporary work adjustment will be approved. Temporary work adjustments must be analyzed by the department and may be approved based on the needs and abilities of the department using fair and objective criteria.

Employee Information

Name: _____ Position: _____
Email Address: _____ Home/Cell Phone: _____
Department: _____ Work Phone: _____
Supervisor: _____

High-Risk Individual – CDC Criteria

The CDC has warned that older adults (age 65 or older) and people of any age who have one of the following serious underlying medical conditions might be at higher risk for severe illness from COVID-19:

- Chronic lung disease or moderate to severe asthma;
- A serious heart condition;
- Immunocompromised (many conditions can cause a person to be immunocompromised, including cancer treatment, smoking, bone marrow or organ transplantation, immune deficiencies, poorly controlled HIV or AIDS, and prolonged use of corticosteroids and other immune weakening medications);
- Severe obesity (body mass index [BMI] ≥ 40);
- Diabetes;
- Chronic kidney disease undergoing dialysis; or
- Liver disease;
- Those who are pregnant.

Employee Certification

I hereby certify:

- ☐ I meet one or more of the CDC's criteria to be considered an individual at high risk (set forth above).*
- ☐ I live with _____, who is an individual who meets one or more of the high risk criteria above and I am unable to adjust my living situation to avoid close contact with them.*
- ☐ I am age sixty-five (65) or older or live with an individual who is age sixty-five (65) or older.
- ☐ I have a personal reason (not related to the CDC high-risk criteria) that I would like considered for a TWA. I understand that the details of my request will be shared with my SLT member and supervisor and that approval of the requested TWA is at the discretion of the SLT Member/supervisor. The reason for my request is (please describe in detail): _____

I am requesting the following TWA:

- ☐ Unpaid Leave of Absence from _____ to _____
- ☐ Working remotely from _____ to _____
- ☐ Other: _____

Employee Signature: _____ Date: _____

* Health Care Provider Certification (Required for an Individual Who is Under 65 and at High Risk)

I hereby certify that the above-referenced individual meets one or more of the High Risk Individual Criteria outlined above.

Health Care Provider Signature: _____ Date: _____
Health Care Provider Name: _____

Return completed form to the OWU Human Resources Department, hr@owu.edu