

Rowan University Employee Request Form COVID-19-Based Further Accommodation/Modification

As part of Rowan University's efforts to address the on-going pandemic situation and to re-establish a return to campus work environment, Rowan seeks to establish a set of protocols ensuring reasonable measures will be in place for a safe working environment for all of its employees. With this goal in mind, Rowan strives to implement practicable return measures as recommended by relevant authorities (including governmental and other reliable sources). Some of these accommodating measures may be university-wide, and others may vary by department, depending on specific departmental realities and requirements. These measures may include (but are not limited to) things such as staggered shifts, mandated use of protective gear, temperature scans, and room-occupancy limitations. The specific accommodating measures that will be applicable to each department and each employee will be announced to employees by their supervisory and management teams as return-to-campus plans are finalized.

In instances where an employee feels that the applicable university or departmental accommodating measures may not reasonably adequately address the employee's particular set of health-related circumstances, the employee may request from the University further accommodations or modifications. These requests will be considered on a case-by-case basis to see if any further reasonable accommodations/modifications can be provided to address the employee's circumstances beyond the accommodating measures already adopted by the University and/or department or otherwise not addressed by other relevant University policies or governmental laws/programs.

Please note that the submission of such a request for further accommodation/modification does not guarantee or imply that any such further reasonable accommodation/modification can be found or granted. Also, please specifically note that a further accommodation/modification may be granted to the employee, but the granted further accommodation/modification may differ from the specific one requested by the employee. Further, please note that if a request is made that should be addressed by another university policy or governmental law/program, this request may be redirected to that other avenue and addressed under those parameters.

The following page is to be completed by the employee and the employee's medical provider, who is to certify to the accuracy of the employee's request and be reasonably available for any relevant follow-up with the University in furtherance of the consideration and/or processing of the employee's request.

Please return all completed forms and documentation to the Office of Human Resources (Benefits) for consideration. Completed Requests should be sent to HR-FA@rowan.edu and also Mroz@rowan.edu

COVID-19-Based Further Accommodation/Modification Request Form

Name of Employee: _____

University E-mail Address: _____ Phone Number: _____

Job Title: _____ Department: _____

Immediate Supervisor: _____ Department Head: _____

Description of Circumstances for which Employee is seeking Further Accommodations/Modifications:

Description of Further Accommodations/Modifications Sought: _____

Explanation as to why Existing Workplace Accommodations/Modifications in place do not Suffice: _____

(PLEASE NOTE, EMPLOYEE MUST ALSO HAVE HIS/HER MEDICAL PROVIDER COMPLETE THE MEDICAL PROVIDER'S CERTIFICATION, WHICH IS ATTACHED TO THIS FORM AS WELL)

Consent for Release of Information:

I, _____, hereby give my written consent for the Office of Human Resources to release information considered pertinent (psychological and/or medical) with necessary University personnel for the sole purpose of determining eligibility and implementation of any further accommodations/modifications requested or deemed necessary.

EMPLOYEE SIGNATURE: _____ **Dated:** _____

COVID-19-Based Further Accommodation/Modification
Medical Provider Certification

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Name of Employee: _____

Name of Medical Provider: _____

Medical Provider Address: _____

Phone Number: _____ **E-mail address:** _____

Description of Circumstances Faced by Employee for which Employee is seeking Further Accommodations/Modifications: _____

Medical Rationale Explaining Why Employee Needs Further Accommodations/Modifications and why existing protective measures do not suffice: _____

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Medical Provider Certification

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Further Accommodations/Modifications Requested: (Please check and describe)

_____ **Enhanced Social Distancing.** How many feet apart: _____

_____ **Separate/limited Workspace Area.** (Description of Altered Workspace Parameters): _____

_____ **Additional Personal Protective Equipment.** (Description of Personal Protective Equipment): _____

_____ **Alterations to work schedule.** (Description of Altered Work Schedule): _____

_____ **Offsite work.** (Description of Parameters, including proposed length of time): _____

_____ **Other.** (Please describe in full detail): _____

Physician Signature: _____

License #: _____

Date: _____

HUMAN RESOURCES SECTION:

Disposition of Request: **APPROVED:** _____

NOT APPROVED: _____

If REQUEST APPROVED:

Description of further accommodation(s)/modification(s) granted: _____

End date of further accommodation(s)/modification(s) granted: _____

Any other relevant details: _____

If REQUEST RE-DIRECTED TO ANOTHER UNIVERSITY POLICY OR GOVERNMENTAL LAW OR PROGRAM:

What policy/law/program: _____

HR Signature:

Dated:

Print Name:

Print Title:

HUMAN RESOURCES REFERENCE:

Checklist:

1. All relevant physician's notices received, reviewed, and contacted (if necessary):

Physician name:

-notes:

Physician name:

-notes:

Physician name:

-notes:

2. Employee's Supervisor/Manager contacted and consulted regarding feasibility of further accommodation/modification requested:

Name of Supervisor/Manager:

-notes:

Name of Supervisor/Manager:

-notes:

3. Review of whether employee request is more appropriately handled under another law or benefit:

| | | | | |
|----------|-----|---------------|-----|--------------|
| FMLA/FLA | ___ | Unemployment | ___ | Other: _____ |
| ADA | ___ | TDI | ___ | |
| FFCRA | ___ | Permanent Dis | ___ | |
| CARES | ___ | W/C | ___ | |

4. Notification provided to employee's supervisor/manager:

Who: _____

Date: _____