High-risk Employee Medical Information Request Form
*****Confidential Personnel Document*****

NOTE: This form is to be used for employees who are at high-risk of severe illness under the Health Emergency Labor Standards Act (HELSA) effective May 11, 2021.

A Pierce College employee has reported they cannot perform the following essential function(s) of their position because of their high-risk condition. The employee has disclosed that due to age or an underlying condition as defined by the Center for Disease Control and Prevention (CDC) they are at high-risk of severe illness from COVID-19. We are requesting you complete the following form to help us to understand the employee's job-related limitations and to make decisions regarding reasonable accommodation. To assist you in completing the form, I have attached the following:

1. Signed Waiver and Authorization to Release Information
2. Current Position Description
3. List of Essential Job Functions
4. Department/Division Safety Plan* *may or may not be included depending on the timing of the request.*

Employee Name (First):	**Employee Name (Last):**
Employee Job Title:	**Employee Department:**
List of Essential Job Functions:	**List of Essential Job Functions:**

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's 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 or an embryo lawfully held by an individual or family member receiving assistive reproductive services. 29 CFR § 1635.8(b)(1)(i)(B).

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Section I

1. What is your area of practice and/or medical expertise?

2. The employee has disclosed that due to age or an underlying condition as defined by the Center for Disease Control and Prevention (CDC) they are at high risk of severe illness from COVID-19. Does the employee suffer from one of these conditions? ***NOTE: Please DO NOT include the specific condition in your response to this question.***

☐ YES ☐ NO

3. Does the condition place the employee at permanent risk of severe illness from COVID-19?

☐ YES ☐ NO

4. If not permanent, what is the anticipated duration of the risk of severe illness from COVID-19 caused by the condition?

Start date: End date:

5. In your medical opinion, does the employee's condition(s) have a **substantially limiting*** effect on the employee's ability to perform the job functions listed above and/or on their ability to maintain regular and predictable attendance at the work site?

☐ YES ☐ NO

*An effect is substantially limiting if it considerably or to a large degree limits the employee's ability to perform the function. You should examine the restriction as to the condition, manner, or duration under which the individual performs the activity as well as the employee's vaccination status and personal protections available in the workplace.

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Section II

1. Please describe, in as specific terms as you can, how the impairment limits this employee's ability to perform those job functions as listed and/or to maintain regular and predictable attendance at the work site.

2. Are there steps the employer could take to enable the employee to return to the workplace?

☐ YES ☐ NO

If so, what steps can be taken?

3. In your medical opinion, are there any other accommodations that would permit the employee to resume the full duties of their position?

☐ YES ☐ NO

If so, please list the accommodations:

4. In your medical opinion, would a leave of absence be effective in allowing the employee to return to the full duties of their position at the conclusion of the leave?

☐ YES ☐ NO

5. In your medical opinion if a leave of absence is indicated, what is the anticipated duration of leave required that would then permit the employee to resume the full duties of their current position?

Start date: End date:

I, _____, declare in my professional opinion that the above responses are true and accurate to the best of my knowledge and ability.

Signature: _____

Date: _____

Please return this completed form to:

Pierce College
Attn: Human Resources Department
9401 Farwest Drive SW
Lakewood, WA 98498
Email: benefits@pierce.ctc.edu
Fax: 253-964-7339
Phone: 253-964-7342

We would very much appreciate your cooperation by completing your response no later than 5 business days from receipt. To avoid delay, please feel free to electronically transmit your response to the following fax number: **253-964-7339**

If you have any questions, please do not hesitate to contact *Human Resources Consultant – Leave and Accommodation,* Serena Mitchell, at 253-912-2343.

Check all that are attached:

◯ Job Description ◯ Employee's Authorization to Release Medical ◯ Dept./Division Safety Plan