
Employee (Patient) Name

Date of Birth

L#

I have reviewed the Job Description for the above-named patient (employee) and can provide the following clarification on their work restrictions related to COVID-19:

1. Do they have a medical and/or psychological impairment that limits their ability to engage in a major life activity, such as the ability to work, care for themselves, perform manual tasks, walk, see, hear, eat, sleep, or engage in social activities?

NO, this patient does not have a physical or mental impairment that limits their ability to engage in a major life activity.

YES, this patient has a PHYSICAL and/or MENTAL impairment that limits their ability to engage in a major life activity.

2. If the answer to question number one is yes, does the impairment currently affect their ability to perform the essential functions of their job as described in the job description provided?

NO, their impairment does not limit their ability to perform all of the essential functions of their position as defined in the job description provided.

YES, their impairment does affect their ability to perform **one or more** of the essential functions of the position as defined in the job description provided.

3. Do they have a disability and/or medical condition that makes them “at an increased risk” as outlined by the Centers for Disease Control (CDC) as it pertains to COVID-19?

NO, the patient DOES NOT HAVE a disability and/or medical condition that makes them “at an increased risk” as outlined by the Centers for Disease Control (CDC) as it pertains to COVID-19.

(Please skip to question #10 and sign, date and return the form).

YES, the patient DOES HAVE a disability and/or medical condition that makes them “at an increased risk” as outlined by the Centers for Disease Control (CDC) as it pertains to COVID-19.

a. **PLEASE IDENTIFY WORKPLACE RISKS THAT NEED TO BE ACCOMMODATED OR MITIGATED TO ENSURE A SAFE WORK ENVIRONMENT FOR YOUR PATIENT. WHAT IS IN THE PHYSICAL WORKPLACE THAT IS A MEDICAL RISK FOR YOUR PATIENT?**

b. **PLEASE IDENTIFY WORKPLACE FACTORS THAT MUST BE PRESENT IN A WORKPLACE TO ENSURE YOUR PATIENT IS SAFE. WHAT ACCOMMODATIONS NEED TO BE IMPLEMENTED FOR YOUR PATIENT IN ANY WORK ENVIRONMENT THEY WORK IN?**

4. Lane Community College has implemented the following social distancing and cleaning protocols which meet or exceed OSHA and CDC guidelines for workplace safety:
- Plexiglass separations or other physical partitions between the public and employee workstations
 - Persons sit no less than 6 feet from each other
 - Occupancy limits are strictly adhered to at any one time
 - Staff have varied schedules and student enrollment is limited by classroom size
 - Restrooms are cleaned daily
 - Masks are required in all places unless alone in their own office, with walls that extend from floor to ceiling and door is closed
 - Masks must be securely closed above nose, below chin, and on both sides of the face

The above safety measures have been taken to protect your patient and their colleagues as employees return to working on campus. Are the above measures sufficient to support your patient to return to the workplace?

- YES, the above measures are sufficient to support my patient to return to the workplace.
- NO, the above measures are insufficient to support my patient to safely return to the workplace. The following safety precautions also need to be implemented / present: (please be specific)

5. Lane Community College has identified safe ways to support staff to return to work and to support the operations, but in limited capacities. One of the ways that they have been able to reduce interactions is by assigning all staff, that medically can, a small portion of on-site duties. The College wants to support their disabled employees, but they also want to find creative and protective ways to “share the load” of work, when medically safe. **As such, can your patient perform minimized tasks on-site?**

- YES, a minimized on-site assignment IS medically allowable. My patient would
- not require additional PPE other than a mask.
 - require the following additional PPE (please list):

- NO, a minimized on-site assignment is NOT medically allowable for the following reasons:
(Please be specific as to what interactions are restricted and would not be able to be done safely.)

If you have indicated that your patient **CAN** perform minimized on-campus tasks, **please skip the rest of the questions and sign and date the bottom of the questionnaire.**

If you have indicated that your patient **CANNOT** perform minimized on-campus tasks, **please complete the rest of the questionnaire.**

6. **COMMUTING CLARIFICATION:** Lane Community College wants to be sure that the request for a work-from home accommodation is not related to a commuting reason. Is your patient's request for a work-from-home accommodation related to their commute?

- NO, the recommendation for an accommodation is NOT related to my patient's commute.
- YES, the recommendation for an accommodation IS related to their commute. The commute concern relates to:
 they use public transportation or other, please explain:

7. **PERSONAL PROTECTION EQUIPMENT CLARIFICATION:**

a. Does your patient's medical condition require specific personal protection equipment?

- NO, their medical condition DOES NOT require specific personal protection equipment.
- YES, their medical condition DOES require specific personal protection equipment as follows:

(check all that apply)

- Cloth or Paper Mask
- Medical Mask
- Respirator with rating greater than: _____
- Face Shield
- Hand Gloves
- Eye Protection
- Gowns
- Aprons
- Eye Protection
- Footwear Covers
- Other: _____

b. Does your patient's medical condition preclude them from using specific personal protection equipment?

- NO, their medical condition DOES NOT preclude them from using personal protection equipment.
- YES, their medical condition DOES preclude them from using specific personal protection equipment as follows:

(check all that apply):

- Cloth or Paper Mask
- Medical Mask
- Respirator with rating greater than: _____
- Face Shield
- Hand Gloves
- Eye Protection
- Gowns
- Aprons
- Eye Protection
- Footwear Covers
- Other: _____

c. Other / Additional Information: _____

8. **VACCINATION CLARIFICATION:** The College is hopeful that with vaccines becoming more readily available, that vaccinated employees may have more abilities to return to the physical workplace. Please note that the workplace will still require the wearing of masks for all persons, and social distancing – even for persons who are vaccinated. As such, we request clarification on the following:

a. Is your patient medically expected to be eligible to receive the COVID-19 vaccine?

NO, they are medically restricted from being administered a COVID-19 vaccination due to their personal medical condition.

YES, they are medically ABLE to receive a COVID-19 vaccination when they become eligible.

OTHER: _____

b. If you have RESTRICTED your patient from being in the workplace at this time, and if you have indicated in question #8a above that your patient IS medically expected to be eligible to the COVID-19 vaccine, will any restrictions listed above, which may limit their ability to return to the physical workplace, end 2 weeks after their final dose?

YES, 2 weeks after they have their final dose of vaccine, they can return to the workplace with the current CDC social distancing and mask wearing precautions in place.

NO, even after receiving the vaccines, they remain restricted from working in-person in the workplace.

OTHER / ADDITIONAL INFORMATION: _____

c. If you have answered NO to question #8b and that your patient CANNOT return to the workplace even after they are vaccinated, please clarify how long the employer would need to expect your patient to be restricted from returning to performing work in the physical workplace.

PERMANENTLY, they would not be expected to be able to return to working in the physical workplace.

TEMPORARILY THROUGH _____ (DATE), on or about this date it would be expected that they will be medically released to return to work in the physical workplace.

UNKNOWN, my patient will need to remain out of the workplace until there is a designation by the CDC of “herd immunity” or that there is no longer a risk of a negative outcome should they contract COVID-19.

ADDITIONAL CLARIFICATION: _____

9. **ESSENTIAL FUNCTIONS / JOB DESCRIPTION REVIEW:** In reviewing your patient’s Job Description are there any unmodified job activities listed that you would restrict your patient from doing, either partially or wholly, in addition to what is listed above?

NO, they are unrestricted in the performance of any additional physical, mental and emotional demands listed in their Job Description, other than what is listed above.

YES, they have the following additional work restrictions / functional limitations:

a. Essential Function / Task: _____

Limitation / Restriction _____

b. Essential Function / Task: _____
Limitation / Restriction: _____

c. Essential Function / Task: _____
Limitation / Restriction: _____

10. **DURATION OF RESTRICTIONS:** Please confirm the duration of restrictions by checking the appropriate box below:

- Restrictions are **TEMPORARY** through _____ (**date**)
- Restrictions are **PERMANENT**
- Restrictions are expected to continue as follows (please explain): _____

11. **Additional Restrictions / Accommodation Suggestions:** Please use the space below to include any additional information that you believe would be helpful to the interactive process for this employee. **Please do not list any information pertaining to medical condition or diagnosis.**

Provider Name, Clinic, and Address

Provider Signature

Date Signed

RETURN A COPY OF THIS FORM TO:
HEIDI MORALES
LANE COMMUNITY COLLEGE
HUMAN RESOURCES
FAX: (541) 463-3191
EMAIL: moralesh@lanec.edu