LOUISIANA TECH UNIVERSITY

Work Accommodation Request Form

Employees who are requesting work accommodations due to the COVID-19 pandemic must complete and submit this request form along with designated supporting documentation to Human Resources.

Employee Name:	Employee ID#
Employee Job Title:	Employee Department:
Employee Phone #:	Employee E-mail:
Supervisor Name:	Supervisor E-mail:

VOLUNTARY DISCLOSURE OF HEIGHTENED RISK OR ACCOMMODATION NEED

I am requesting a work accommodation for the following reason:

Please describe what underlying medical condition puts you at a greater risk for severe illness from the COVID-19.

Please attach documentation from a medical provider that supports the basis for your request (Documentation is not required if the condition is known or obvious to the University). Documentation must be typed on office or practice letterhead and signed by a professional who is licensed or certified in the area for which the diagnosis is made.

REQUESTED WORK ACCOMMODATION

What specific work accommodations are you requesting? Please describe the specific request and how you expect this accommodation to effectively assist you to perform the essential functions of your position:

Duration requested (not to exceed one quarter):

EMPLOYEE CERTIFICATION

When requesting the work accommodation, I agree that to the best of my knowledge, the information I have provided is truthful and accurate. I understand that any willful misrepresentation or falsification may lead to ineligibility for these benefits and may be cause for disciplinary action. I agree to provide additional documentation if needed. I understand that each request is considered within the context of submitted documentation, job requirements, and available resources and that I may not be provided the specific accommodation I have requested. I agree that if I fail to perform my essential duties and responsibilities, the work accommodation may be revoked.

Employee Signature: _____ Date: _____

Dean/Division Head Approval of Alternative Work Accommodation: Yes ☐ No ☐

Notes:

Dean/Division Head Signature: _____ Date: _____

HUMAN RESOURCES USE ONLY

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

Work Accommodation Decision: ☐ Approved ☐ Denied ☐ Modified as outlined below: Modifications:

APPEALS PROCESS

Does Employee request an appeal of supervisor decision? Yes ☐ No ☐

Appeals will go to Human Resources and then to a University-Wide Appeals Panel for review.

Employee must submit their appeal to Human Resources within five (5) business days.

EMPLOYEE AUTHORIZATION and PHYSICIAN CONTACT INFORMATION: The physician may receive communication form the institution on your impairment/disability and recommendations for work accommodations.

I authorize a representative of Human Resources to communicate directly with my health care provider for confirmation of my underlying health condition and, if needed, clarification regarding my need for a work accommodation.

Employee Signature: _____ Date: _____

Physician's Name:	Physician's E-mail:
Physician's Phone #:	Physician's Fax #:
Physician's Address:	

PHYSICIAN CERTIFICATION (Not required if the underlying health condition is known or obvious)

Does the employee have an underlying medical condition that presents a greater risk of severe illness for COVID-19? Yes ☐ No ☐

If yes, what is the underlying medical condition(s)?

Describe relevant medical facts related to the condition(s) for which the employee is seeking work accommodations.

Estimate the beginning and ending dates for the period of work accommodations.

Physician Signature: _____ Date: _____