

Accommodations for an employee's own health condition, related to COVID-19 or not, will be handled through the university's interactive process for employee accommodations. **All documentation related to an accommodation request should be sent to the Office for Accessibility and Gender Equity through email at adaservices@ufl.edu.** Please note that in order to process the request, the Office must receive the Temporary COVID-19 Accommodation Request Form and the Medical Certification Form or a similar letter on official letterhead from the treating medical provider, that addresses the information requested. **All fields on these forms must be completed for processing to occur.**

SECTION 1: EMPLOYEE INFORMATION

Employee Name: _____ **UFID:** _____
Job Title: _____ **Department:** _____
Supervisor Name: _____ **Supervisor Email:** _____

SECTION 2: QUALIFYING MEDICAL CONDITION OR DISABILITY

Certain medical conditions included in the CDC guidelines related to increased COVID-19 risks may also be a disability under the ADA depending on the condition and its impact on the individual. An individual with a condition identified as "at increased risk" by the CDC may have a disability under the ADA. If the employee has a disability, the University, in consultation with UF Health expertise, will determine if a reasonable accommodation is available and not an undue hardship under the law. Such reasonable accommodations may include increased classroom safeguards or other appropriate measures. Living with an individual who is at increased risk does not constitute an employee disability.

1. Please select all the medical condition(s) below for which you self-identify.

Chronic Kidney Disease Obesity (body mass index [BMI] of 30 or higher) Sickle Cell Disease Type 2 Diabetes Mellitus
COPD (chronic obstructive pulmonary disease) Immunocompromised state (weakened immune system) from solid organ transplant
Serious heart conditions (heart failure, coronary artery disease, or cardiomyopathies) Cancer Pregnancy
Down Syndrome
Other (describe in the provided text box)

2. Please describe how this medical condition impacts your ability to complete your job duties?

3. Please describe the accommodation(s) that you are requesting. Possible accommodations include; additional protective equipment, enhanced social distancing measures, or a modified work schedule (staggered shifts).

SECTION 3: CERTIFICATION OF INFORMATION

Phone: _____ **Email:** _____
Signature: _____ **Date:** _____