USG COVID-19 Alternate Work Arrangement Request Form

In addition to accommodations provided in accordance with the ADA, the University System of Georgia (USG) provides alternative work arrangements for employees in response to public health emergency guidance when it will enable the performance of the employee's essential functions and when doing so does not create an undue hardship to the institution.

Employees who are requesting alternative work arrangements must complete and submit this request form along with designated supporting documentation to Human Resources at 706-721-3836.

- A confidential interactive discussion with Human Resources is encouraged for employees who are seeking reasonable accommodations.
- If more information is needed, the institution may request that you ask your health care provider to confirm your disability and/or the need for the requested alternative work arrangements.
- It is your responsibility to ensure that your health care provider statement or other supporting documentation is returned to the Office of Human Resources.
- You are not required to disclose personal health information to your immediate supervisor regarding the medical basis for a requested alternative work arrangement. Medical records are confidential and maintained in the Office of Human Resources only.

To request assistance with the process or form, please contact Chris Hunt by telephone, 706-721-3836 or email, chunt@augusta.edu. Submit all completed forms to AU_HR_CONFIDENTIAL@augusta.edu or by fax at 706-721-1996.

EMPLOYEE INFORMATION	
Employee Name:	Employee ID #:
Employee Job Title:	Employee Department:
Employee Phone Number:	E-mail:
Immediate Supervisor Name:	Supervisor E-mail:
Department Chair/Director (if different from immediate supervisor):	

VOLUNTARY DISCLOSURE OF HEIGHTENED RISK:

What CDC/Georgia Department of Public Health circumstance or underlying medical condition puts you at a greater risk for severe illness from the public health emergency?

REQUESTED/SUGGESTED ALTERNATIVE WORK ARRANGEMENTS

This is a *(choose one)*: ☐ New request for alternative work arrangement

☐ Request for an extension and/or alteration of existing accommodations.

→ If this is an extension and/or alteration of an existing accommodation you will need to contact Antionette Lewis at 706-721-7285 or anlewis@augusta.edu to continue the current AU ADA Process.

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What specific alternative work arrangements are you requesting? Please select from the options below:

- ☐ Modification of job duties (provide additional details in the Job Duties and Essential Function section below).
- ☐ Modification of work schedule (telework, flexible scheduling, reduction of hours, etc.).
- ☐ Modification of physical environment (i.e. plexiglass guard, alternative on-site work location).
- ☐ Leave of absence.
- ☐ Classroom Reassignment (faculty/staff only).

If the request is other than modification of job duties, please describe specific request based on the selection above:

Duration requested - Begin Date **End Date** (until end of public health emergency per CDC/GDPH)

JOB DUTIES and ESSENTIAL FUNCTIONS

Please describe each of your primary job duties (your direct supervisor will be contacted for the essential functions of your job):

Which of your duties do you perceive could be performed with alternative work arrangements, and how?

JUSTIFICATION NARRATIVE

Please describe how the alternative work arrangements requested above will allow you to perform the essential functions of your position (attach separate sheet if necessary):

CERTIFICATION of HEALTH CARE PROVIDER

☐ Health Care Provider Statement (Provider documentation of CDC/GDPH recognized circumstance or underlying health condition together with alternative work arrangements suggestions.

☐ Other Supporting Documentation (Record of diagnosis or other supporting documents that meet public health emergency guidance)

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PHYSICIAN CONTACT INFORMATION: The physician may receive communication from the institution HR requesting information on your impairment/disability and recommendations for alternative work arrangements.

Physician's Name:	Physician's Email Address:
Physician's Telephone #:	Physician's Address:
Physician's Fax:	

EMPLOYEE AUTHORIZATION

☐ I authorize a representation of the Office of Human Resources to communicate directly with my health care provider for confirmation of the CDC/GDPH recognized circumstance or underlying health condition and clarification regarding my need for an alternative work arrangement.

Employee Signature: _____ Date: _____

EMPLOYEE CERTIFICATION

I certify that the above information is accurate and complete. I understand that I must contact the office of Human Resources regarding any changes or deviations to this request once submitted.

Employee Signature _____ Date _____

HUMAN RESOURCES RESPONSE

On _____ we received your request for the following alternate work arrangement/accommodation and the required documentation (if applicable): _____

_____

After our review and coordination with you department, the above alternative work arrangement/accommodation is: ☐ Approved ☐ Denied ☐ Modified as outlined: _____

_____

This alternate work arrangement/accommodation is approved for the following dates: _____

_____

Name of Institutional Representative:

Signature of Institutional Representative: Date: