



UNT SYSTEM™



## Medical Certification Form for Employees in COVID-19 High Risk Category

To the medical practitioner: The employee listed below has identified himself/herself as your patient and has indicated that he or she is in a category identified by the Centers for Disease Control (CDC) as [high risk for severe illness in contracting the COVID-19 virus](#) due to an underlying medical condition. The employee has requested modifications to the work environment and/or job functions as a direct result of and for the duration of the COVID-19 health pandemic. Your assistance is appreciated in providing information to determine appropriate personal protective equipment (PPE), work environment modifications, or specific job functions to mitigate his or her risk of contracting the COVID-19 virus.

Patient Name: \_\_\_\_\_ Job Title: \_\_\_\_\_

Campus: UNT    DAL    HSC    SYS

1. Does this individual have an underlying health condition which places them at higher risk of severe illness in contracting the COVID-19 virus, [as defined by the CDC](#)?    \_\_\_\_\_ No    \_\_\_\_\_ Yes

2. If yes, please indicate the type of underlying health condition:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Describe the PPE, work environment or job duty modification(s) that are required for the employee to mitigate his or her risk in the workplace with respect to the COVID-19 virus.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Are the modification(s) required solely for the purpose and duration of the COVID-19 health pandemic?

\_\_\_\_\_ Yes  
\_\_\_\_\_ No (Explain) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. What is the duration or expected duration of the required modifications?

\_\_\_\_\_  
\_\_\_\_\_

6. Does this individual's health condition substantially limit any major life activities, as defined by the ADA/ADAAA?

\_\_\_\_\_ No  
\_\_\_\_\_ Yes (Explain)\* \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\*If yes, please complete the [Medical Practitioner Certification for a Request for Disability Accommodation](#).

*As defined by the ADAAA, major life activities include, but are not limited to: caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working. For more information, visit <https://www.dol.gov/ofccp/regs/compliance/faqs/ADAFaqs.htm>.*

Name of Medical Practitioner: \_\_\_\_\_ Phone: \_\_\_\_\_

Medical Practitioner's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Please return the completed form to the appropriate Human Resources department:**

UNT	<a href="mailto:HRAdministration@untsystem.edu">HRAdministration@untsystem.edu</a>
UNT HSC	<a href="mailto:HSC.HR@untsystem.edu">HSC.HR@untsystem.edu</a>
UNT Dallas	<a href="mailto:HR@untdallas.edu">HR@untdallas.edu</a>
UNT System Administration	<a href="mailto:HR@untsystem.edu">HR@untsystem.edu</a>