UNIVERSITY OF
LOUISVILLE.

COVID-19 MODIFICATION REQUEST FORM
Request for Modification

Instructions for Section I

The Provost's Office of Faculty Affairs is responsible for monitoring and addressing COVID-19 modification requests. Please fully answer each item in Section I, then provide the form, along with a copy of your job description, to your healthcare provider to complete Section II. Forward completed forms and attachments to your unit Faculty Affairs Office for processing.

Section I: for Completion by Employee

Last Name: ___________________________________ First Name: _________________________________

Mailing Address: ____

City: ____ State: _______ Zip Code: _______________

E-mail: ______________________________________ Home/Mobile Phone: __________________________

Work Phone: _________________________________ Department: ________________________________

Job Title: _____________________________________ Employee ID: _______________________________

Supervisor's Name: ____________________________ Supervisor's Phone Number: ____________________

Describe your current job duties requiring a modification because of a health concern:

Describe the functional limitations caused by your health concern for which you are requesting a modification. Use additional pages, if necessary. (Attach any additional medical documentation):

Describe any modification(s) you believe would minimize or eliminate the functional limitations listed above. Include any available information relating to source, name of device, etc. Use additional pages, if necessary:

AUTHORIZATION

I have voluntarily completed this COVID-19 Modification Request Form and all information provided is true and accurate to the best of my knowledge or belief. I give UofL permission to explore coverage and reasonable modifications. This may include speaking to appropriate University personnel and/or my health care professional, and acknowledge that such communication is job-related and consistent with business necessity. I understand that all information obtained during this process will be maintained and used in accordance with medical confidentiality requirements. I further understand that I may be required to provide appropriate documentation of my medical concerns, including the impact of the functional limitations on my ability to perform the essential functions of my job.

Print Name of Employee: ____

Signature of Employee: ____ Date: __________________

Instructions for Section II

Once you have completed section I, please submit section II to your healthcare provider for completion, along with section I and your job description. Once your healthcare provider has completed section II, please submit both sections to your unit Faculty Affairs Office for processing.

Section II: for Completion by Healthcare Provider

Instructions for Section II: Please fully answer all applicable parts, based on your medical knowledge, experience, and examination of the patient. The employee should provide you with a copy of their job description. Please refer to the following sections of the job description when completing this form: job duties, physical effort, and essential functions. Please attach additional pages if more space is needed.

Healthcare Provider's Name: ____

Mailing Address: ____

City: _____________________________________ State: _______ Zip Code: _______________

Phone Number: ____________________________ Fax Number: ______________________________

Employee (Patient) Name: ____

Does this employee have a physical or mental impairment?

Yes No

If yes, state the type of impairment: ____

List the major life activities limited by the impairment and describe any limitations (i.e. number of pounds that can be lifted, walking distance, alternate sitting/standing, etc.):

What is the duration or expected duration of the employee's impairment?

Can the employee perform all job duties listed in the job description?

Yes No

If no, state which job functions cannot be performed and why:

Describe any reasonable modifications that would allow the employee to perform the job functions listed above (if medical leave is one of the possible modifications, please provide an estimated duration for the leave):

Would performing any job function listed in the job description result in a direct safety or health threat to the employee or other people (coworkers, the general public, etc.)?

Yes No

If yes, state which job functions would pose a threat, what that threat could be, and any reasonable modification that would eliminate or reduce the threat to an acceptable level:

Signature of Healthcare Provider: ____ Date: _______________________

For University Use Only: Date Form Received: _______________________ Signature: ___________________