WASHINGTON STATE UNIVERSITY

Health Emergency Labor Standards Act High Risk Employee Accommodation Employee Request and Health Care Provider Certification

Please return form to:	Human Resource Services (HRS)
Electronic (scan or photo)	HRS.Disabilityservices@wsu.edu
OR Fax:	509-335-1259
Office Location:	139 French Administration Bldg.
OR Mailing address:	PO Box 641014* Pullman, WA 99163
Questions? Call HRS at:	509-335-4521

HIGH RISK EMPLOYEE - ACCOMMODATION REQUEST

The Washington Health Emergency Labor Standards Act (HELSA) (ESSB 5115-2021) passed May 11, 2021, provides certain protections in employment, including accommodations to limit the potential risk of severe illness from the disease that is the subject of the current public health emergency. Accommodations under this process are only in effect during a declared public health emergency.

A complete application and medical certification is required to process a request for an Accommodation under HELSA. Employee completes Sections A through F and the Employee Name field on top of the page 2. The Health Care Provider (HCP) completes Sections G through I. Once form is fully competed it is to be returned to HRS directly, in order for HRS to review and process your request.

A EMPLOYEE/PATIENT INFORMATION

Name (Last, First, MI)	WSU ID #	Personal Phone
Personal Mailing Address (Street/PO Box, City, State, Zip Code)		Personal Email

B CERTIFY REASON FOR REQUEST ELIGIBLE FOR THIS PROGRAM

☐ I am a person who due to age or an underlying health condition as defined by the U.S. Centers for Disease Control (CDC) is at a high risk of severe illness from the disease that is the subject of the current public health emergency.

C IDENTIFY WORK STATUS as of May 11, 2021. Check ALL that apply

☐ Working at regular WSU work location	☐ Teleworking
☐ Working at an alternative location on a WSU site	☐ On Leave

D TYPE OF WORKPLACE ACCOMMODATION REQUEST

☐ Work at an alternate WSU location. Requested work location if known:_____

☐ Telework for Dates ____/____/____ through ____/____/____.

☐ Leave for Dates ____/____/____ through ____/____/____. Employee: Work with department to account for time off.

☐ Leave and Documentation to provide to Washington State Employment Security Department to apply for benefits.

E DESCRIPTION OF JOB FUNCTIONS

Please provide an overview of your job duties. Include the nature of your work and frequency of contact with other individuals in your normal duties. You may attach a copy of your position description.

F EMPLOYEE DECLARATION

I understand if my request is incomplete or insufficient, WSU may not approve the request. I release appropriate HRS personnel to contact my HCP to authenticate or clarify information provided, if necessary. By signing below, I declare under penalty of perjury under laws of the state of Washington, the foregoing is true and correct and I meet all the requirements necessary for this application associated with HELSA (ESSB 5115-2021).

Employee Signature	Date

G HEALTH CARE PROVIDER COMPLETES SECTIONS H THROUGH I

Information you provide assists WSU in identifying the employee's job-related limitations, the determination of eligibility for the program and what, if any appropriate/available accommodations may be available, taking into consideration the employee's medical condition, vaccination status, and the particular circumstances of their job or workplace. Attach additional information as needed.

H HEALTH CARE PROVIDER STATEMENT

The above employee has reported due to age or an underlying health condition, they are at a higher risk of severe illness from the disease that is the subject of the public health emergency, as defined by the CDC. Does the employee meet the required criteria ? ☐ Yes ☐ No

If Yes, please continue Section H. If No, please complete Section I - HEALTH CARE PROVIDER DECLARATION and return to HRS.

Name of Employee (Last, First, MI)

(Section H Continued) HEALTH CARE PROVIDER STATEMENT

In your medical opinion, does the condition(s) above have a substantially limiting* effect on the employee's ability to perform the job functions listed above?

**An effect is substantially limiting if it considerably or to a large degree limits the employee's ability to perform the function. Please examine the restriction as to the condition, manner, or duration under which the individual performs the activity as well as the employee's vaccination status and personal protections available in the workplace.*

■ Yes ☐ No

If Yes, please continue section H. If No, please complete section I HEALTH CARE PROVIDER DECLARATION and return to HRS.

FUNCTIONAL LIMITATION(S)/IMPAIRMENT(S) PREVENTING EMPLOYEE FROM WORKING ON A WSU WORKSITE

Please describe, in as specific terms as you can, how the impairment limits the employee's ability to perform their job on their regular WSU worksite.

RECOMMENDED ACCOMMODATION

In your medical opinion, are there any accommodations that would permit the employee to resume the full duties of their position on a WSU worksite and/or WSU site modification the employer could make to enable the employee to return to the workplace? (i.e., Private work setting/maximization of social distancing.)

■ Yes ☐ No

If Yes, please list the accommodations or steps that could can be taken to allow the person to work on a WSU site including or in lieu of telework or a leave of absence.

DURATION OF NEED

In your medical opinion, if a leave of absence or telework assignment is recommended, what is the anticipated duration of the accommodation needed that would permit the employee to resume the full duties of their current position? Please note accommodations under this process are only in effect during a declared public health emergency.

From ___/___/_____ (mm/dd/yy) To ___/___/_____ (mm/dd/yy) OR Other (Please describe below)

In your medical opinion, would a leave of absence or telework assignment during the declared public health emergency be effective in allowing the employee to return to the full duties of their position at the conclusion of the public health emergency? ☐ Yes ■ No

If No, what is the anticipated duration of the risk of severe illness from the public health emergency caused by the condition?

From ___/___/_____ (mm/dd/yy) To ___/___/_____ (mm/dd/yy) OR Other (Please describe below)

I HEALTH CARE PROVIDER DECLARATION

I declare, in my professional opinion, the above responses are true and accurate, to the best of my knowledge and ability.

HEALTH CARE PROVIDER NAME (Print or type)	HEALTH CARE PROVIDER SIGNATURE	DATE
HEALTH CARE PROVIDER ADDRESS	CITY, STATE ZIP	
TYPE OF PRACTICE	TELEPHONE	FAX

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual. To comply with this law, we are asking that you do not provide any genetic information when responding to this request for medical information. "Genetic information" as defined by GINA includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services."