

GEORGIA STATE UNIVERSITY
COVID-19 Alternative Work Arrangement Request Form

In response to the COVID-19 public health emergency, Georgia State University (GSU) will provide alternative work arrangements for employees who have an increased risk from COVID-19 as published by the Centers for Disease Control (CDC) and Georgia Department of Public Health (GDPH) when the alternative work arrangement: (1) will enable the performance of the employee's essential job functions; and (2) will not create an undue hardship.

- **Employees must fit into a CDC/GDPH category for increased risk from COVID-19 to be considered for alternative work arrangements in response to the COVID-19 public health emergency.**
- GSU may require certification from your health care provider regarding your qualifying circumstance or health conditions.
- It is the Employee's responsibility to ensure that your health care provider documentation or other supporting documentation is returned to the GSU Benefits.
- Employees may be required to engage in an interactive process with GSU Benefits to explore alternative work arrangement options.
- Employees do not need to disclose their health condition to supervisors. Medical records and information should only be submitted to Benefits, where they are maintained in a confidential manner.
- If approved for an alternative work arrangement, GSU may periodically review the arrangement to confirm that it is enabling the performance of the employee's essential job functions and is not creating an undue hardship. Alternative work arrangements may be changed or discontinued if determined by the University not to be enabling the performance of the employee's essential job functions or to be creating an undue hardship.
- Approved alternate work arrangements will end no later than upon the conclusion of the public health emergency as determined by CDC/GDPH.

Employees requesting alternative work arrangements must submit a completed COVID-19 Alternative Work Arrangement Request Form (Request Form) to the GSU Benefits Office.

RETURN FORM TO:

E-Mail: c19workrequest@gsu.edu
Fax: 404-413-3324
US Mail: ADA Coordinator/Benefits Office
Georgia State University
P. O. Box 3982
Atlanta, GA 30302-3982

For assistance with the request process or form, please contact GSU's Benefits Office at benefits@gsu.edu or 404-413-3330.

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EMPLOYEE INFORMATION		
Employee Name:	Employee ID #:	
Employee Job Title:	Employee Department:	
Home Phone #:	Cell Phone #:	E-mail:
Supervisor Name:	Supervisor E-mail:	
VOLUNTARY DISCLOSURE OF HEIGHTENED RISK:		
What CDC/GDPH published circumstance or underlying medical condition puts you at a greater risk for severe illness from the public health emergency?		

REQUESTED ALTERNATIVE WORK ARRANGEMENTS:	
What specific alternative work arrangement are you requesting? Please select from the options below:	
Modification of job duties. Please describe:	
Duration requested:	until end of public health emergency per CDC/GDPH.
Modification of work schedule (telework, flexible scheduling, reduction of hours, etc.). Please describe:	
Duration requested:	until end of public health emergency per CDC/GDPH.
Modification of physical environment (i.e. plexiglass guard, alternative on-site work location). Please describe:	
Duration requested:	until end of public health emergency per CDC/GDPH.
Leave of absence: Please describe:	
Duration requested:	until end of public health emergency per CDC/GDPH.
Classroom Reassignment. Please describe (include current and desired assignment):	
Duration requested:	until end of public health emergency per CDC/GDPH.

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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 those 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 Certification of CDC/GDPH recognized circumstance or underlying health condition together with alternative work arrangements suggestions.

Other Supporting Documentation (record of diagnosis or other supporting documentation of CDC/GDPH recognized circumstance/underlying health condition).

PHYSICIAN CONTACT INFORMATION: The physician may receive communication from the GSU Benefits Office requesting information about your CDC/GDPH recognized circumstance/underlying health condition and recommendations for alternative work arrangements.

Physician's Name:

Physician's Email Address:

Physician's Telephone #:

Physician's Address:

EMPLOYEE AUTHORIZATION

I authorize a representation of GSU's Benefits Office 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:

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EMPLOYEE CERTIFICATION

I certify that the above information is accurate and complete. I understand that I must contact GSU's Benefits Office regarding any changes or deviations to this request once submitted.

Employee Signature

Date

GSU BENEFITS USE ONLY

All required documentation received from employee: No ___ Yes ___ Received on date:

Documentation confirms CDC/GDPH recognized circumstance/underlying health condition: No ___ Yes ___

Alternative Work Arrangement Approved Denied

If approved, describe alternative work arrangement:

Benefits Representative Signature

Title

Date