

## REQUEST FOR TEMPORARY WORK ADJUSTMENT RELATED TO COVID-19

Employees who are concerned about returning to onsite work because they are a high-risk individual, live with a high-risk individual, or have another COVID-related reason should complete this form. The fully signed form should be sent to UHRM. UHRM will confirm to the supervisor that the employee is eligible to request a **Temporary Work Adjustment (TWA)**. Completing this form is no guarantee that the temporary work adjustment will be approved. Temporary work adjustments must be analyzed by the department and may be approved based on the needs and abilities of the department using fair and objective criteria (with oversight from the cognizant VP).

Employee Information	
Name: _____	Employee ID # _____
Email Address: _____	Home/Cell Phone: _____
Department: _____	Work Phone: _____
Supervisor: _____	Position: _____

High-Risk Individual – CDC Criteria				
<p>The CDC has warned that older adults (age 65 or older) and people of any age who have one of the following serious underlying medical conditions might be at higher risk for severe illness from COVID-19:</p> <table style="width: 100%; border: none;"> <tr> <td style="vertical-align: top; width: 25%;"> <ul style="list-style-type: none"> <li>Asthma: moderate to severe</li> <li>Cancer</li> <li>Cerebrovascular Disease</li> <li>Chronic Kidney Disease</li> <li>COPD</li> <li>Cystic Fibrosis</li> </ul> </td> <td style="vertical-align: top; width: 25%;"> <ul style="list-style-type: none"> <li>Heart conditions such as heart failure, coronary artery disease, cardiomyopathies</li> <li>Hypertension or high blood pressure</li> <li>Immunocompromised due to organ, blood, or bone marrow transplant, immune deficiencies, HIV, use of corticosteroids, or other immune weakening medicines</li> </ul> </td> <td style="vertical-align: top; width: 25%;"> <ul style="list-style-type: none"> <li>Liver Disease</li> <li>Neurologic Conditions such as dementia</li> <li>Overweight (BMI &gt; 25)</li> <li>Pregnancy</li> </ul> </td> <td style="vertical-align: top; width: 25%;"> <ul style="list-style-type: none"> <li>Pulmonary Fibrosis</li> <li>Sickle Cell Disease</li> <li>Smoking</li> <li>Thalassemia</li> <li>Type I or II Diabetes</li> </ul> </td> </tr> </table>	<ul style="list-style-type: none"> <li>Asthma: moderate to severe</li> <li>Cancer</li> <li>Cerebrovascular Disease</li> <li>Chronic Kidney Disease</li> <li>COPD</li> <li>Cystic Fibrosis</li> </ul>	<ul style="list-style-type: none"> <li>Heart conditions such as heart failure, coronary artery disease, cardiomyopathies</li> <li>Hypertension or high blood pressure</li> <li>Immunocompromised due to organ, blood, or bone marrow transplant, immune deficiencies, HIV, use of corticosteroids, or other immune weakening medicines</li> </ul>	<ul style="list-style-type: none"> <li>Liver Disease</li> <li>Neurologic Conditions such as dementia</li> <li>Overweight (BMI &gt; 25)</li> <li>Pregnancy</li> </ul>	<ul style="list-style-type: none"> <li>Pulmonary Fibrosis</li> <li>Sickle Cell Disease</li> <li>Smoking</li> <li>Thalassemia</li> <li>Type I or II Diabetes</li> </ul>
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Employee Certification
<p><b>I hereby certify:</b></p> <p><input type="checkbox"/> I meet one or more of the CDC’s criteria to be considered an individual at high risk (set forth above).*</p> <p><input type="checkbox"/> I live with _____, who is an individual who meets one or more of the high risk criteria above and I am unable to adjust my living situation to avoid close contact with them.*</p> <p><input type="checkbox"/> I am age sixty-five (65) or older or live with an individual who is age sixty-five (65) or older.</p> <p><input type="checkbox"/> I have a personal reason (not related to the CDC high-risk criteria) that I would like considered for a TWA. I understand that the details of my request will be shared with my dean or supervisor and that approval of the requested TWA is at the discretion of the dean/supervisor. The reason for my request is <i>(please describe in detail)</i>: _____</p> <p>_____</p> <p>_____</p>
<p><b>I am requesting the following TWA:</b></p> <p><input type="checkbox"/> Unpaid Leave of Absence from _____ to _____.</p> <p><input type="checkbox"/> Working remotely from _____ to _____.</p> <p><input type="checkbox"/> Other: _____</p>
<p><b>Employee Signature:</b> _____ <b>Date:</b> _____</p>

* Health Care Provider Certification <i>(Required for an Individual Who is Under 65 and at High Risk)</i>
<p>I hereby certify that the above-referenced individual meets one or more of the High Risk Individual Criteria outlined above.</p>
<p><b>Health Care Provider Signature:</b> _____ <b>Date:</b> _____</p> <p><b>Health Care Provider Name:</b> _____</p>

**University Human Resource Management**  
 250 East 200 South, Suite 125, Salt Lake City, Utah 84111 Phone: (801) 581-7447  
 Fax Completed Form to UHRM at: (801) 585-7375 / Email Completed Form to UHRM at: [AskHR@utah.edu](mailto:AskHR@utah.edu)