

# WESTERN CAROLINA UNIVERSITY DOCUMENTATION OF HIGH RISK STATUS FORM

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To initiate this request, you will need to complete section I below. You will need to have your physician or medical provider complete section II (section II is not required when age is the primary high-risk factor). Your physician or medical provider will probably ask you to sign his/her own release form before he/she provides the information requested. Once complete, have your physician or medical provider mail this form directly to Matt Brown, Director of Benefits, 302 H.F. Robinson Administration Bldg., Western Carolina University, Cullowhee, NC 28723 or fax to the attention of Matt Brown, fax number (828) 227-7007. Questions may be directed to Matt Brown at (828) 227-3139 or mbrown@email.wcu.edu.

**Appropriate with all data handling procedures, sensitive medical information will be kept in a locked cabinet and electronic information will be saved to a restricted secure folder. Medical information will be kept confidential and will not be shared with direct supervisors or colleagues. The requested alternative work arrangement must be discussed to gain the appropriate approval or to facilitate discussion of alternatives.**

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## SECTION I (Employee Information):

Name: \_\_\_\_\_ WCU I.D. Number: \_\_\_\_\_

Classification / Title: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_

College / Division: \_\_\_\_\_ Department: \_\_\_\_\_

Work Schedule (Days and Hours): \_\_\_\_\_

Work Location: \_\_\_\_\_

## Assistance Request Information (*Please attach additional sheets as necessary.*)

1. Please describe the nature of the request and the assistance needed.

2. What type of assistance would you recommend? (*Please include alternatives.*)

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Release of Information:

I, , hereby authorize the release of the following information to Western Carolina University for the purpose of determining reasonable assistance.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**SECTION II (To the Diagnosing Professional):**

To ensure reasonable and appropriate assistance, employees must provide current documentation of their high risk or vulnerable status related to COVID-19. The Americans with Disabilities Act identifies a direct threat as an important ADA concept during an influenza epidemic. Based on guidance of the CDC and the public health authorities as of March 2020, the COVID -19 pandemic meets the direct threat standard. As the diagnosing professional, you are asked to fully complete all sections of this form. Additional reports can be attached if necessary. Thank you for your assistance.

I. What is the applicable category of the current CDC guidance of the above condition:

- Age 65 years or older
- Lives in a nursing home or long-term care facility
- People of all ages with underlying medical conditions, particularly if not well controlled, including:
  - Chronic lung disease or moderate to severe asthmas
  - Serious heart conditions
  - Immunocompromised (cancer treatment, smoking, bone marrow or organ transplantation, immune deficiencies, poorly controlled HIV or AIDS, prolonged use of corticosteroids and other immune weakening medications)
- Severe Obesity (BMI of 40 or higher)
- Diabetes
- Chronic kidney disease undergoing dialysis
- Liver Disease

II. Is this person unable to work on-site due to the current COVID-19 pandemic?  Yes  No  N/A

III. Is this person able to work if working from home is an option?  Yes  No  N/A

**Thank you for your assistance in providing this information so that we may provide services as soon as possible. Please attach your business card or other form of identification and mail this document to:**

**Matt Brown, Director of Benefits, 220 H.F. Robinson Bldg., Western Carolina University, Cullowhee, NC 28723**

**Certifying Qualified Medical Provider/License Number:** \_\_\_\_\_

**Name / Degrees / Title:** \_\_\_\_\_

**Business Address:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_ **E-mail Address:** \_\_\_\_\_

**Medical Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_