GHC COVID-19 Alternate Work Arrangement Request Form

In addition to accommodations provided in accordance with the ADA, Georgia Highlands College provides alternative work arrangements for employees in response to public health emergency guidance when it will enable the performance of the employee's essential functions and when doing so does not create an undue hardship to the institution.

Employees who are requesting alternative work arrangements must complete and submit this request form along with designated supporting documentation to the Office of Human Resources at HR COVID-19@highlands.edu.

- A confidential interactive discussion with Human Resources is encouraged for employees who are seeking reasonable accommodations.
- If more information is needed, the institution may request that you ask your health care provider to confirm your disability and/or the need for the requested alternative work arrangements.
- It is your responsibility to ensure that your health care provider statement or other supporting documentation is returned to the Office of Human Resources.
- You are not required to disclose to your immediate supervisor the medical basis for a requested alternative work arrangement. Medical records are confidential and maintained in the Office of Human Resources only.

To request assistance with the process or form, please contact Human Resources at (706) 802-5195 or HR COVID-19@highlands.edu.

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

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REQUESTED/SUGGESTED ALTERNATIVE WORK ARRANGEMENTS**:**

What specific alternative work arrangements are you requesting? Please select from the options below:

☐ Modification of job duties. Please describe:

Duration requested: or, until end of public health emergency per CDC/GDPH.

☐ Modification of work schedule (telework, flexible scheduling, reduction of hours, etc.). Please describe:

Duration requested: or, 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: or, until end of public health emergency per CDC/GDPH.

☐ Leave of absence: Please describe:

Duration requested: or, until end of public health emergency per CDC/GDPH.

☐ Classroom Reassignment. Please describe (include current and desired assignment):

Duration requested: or, until end of public health emergency per CDC/GDPH.

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 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):

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CERTIFICATION of HEALTH CARE PROVIDER	
☐ Health Care Provider Statement (Provider documentation of CDC/GDPH recognized circumstance or underlying health condition together with alternative work arrangements suggestions.	
☐ Other Supporting Documentation (Record of diagnosis or other supporting documents that meet public health emergency guidance)	
PHYSICIAN CONTACT INFORMATION: The physician may receive communication from the institution HR requesting information on your impairment/disability and recommendations for alternative work arrangements.	
Physician's Name: Physician's Telephone #: Physician's Fax:	Physician's Email Address: Physician's Address:
EMPLOYEE AUTHORIZATION	
☐I authorize a representation of the Office of Human Resources 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: ________________________	
EMPLOYEE CERTIFICATION	
I certify that the above information is accurate and complete. I understand that I must contact the office of Human Resources regarding any changes or deviations to this request once submitted. Employee Signature: ___________________________ Date: ________________________	
HUMAN RESOURCES USE ONLY Required documentation (if applicable) received from employee: No ☐ Yes ☐ Received on date: Accommodations Decision: ☐ Approved ☐ Denied ☐ _______Modified as outlined below: Georgia Highlands College HR Representative:	