Health Care Provider's Statement Form (GBC-E-6)

(COVID-19 Medical Inquiry Form)

Staff Member Name: _____

Health Care Provider Name: _____

Health Care Provider License: _____

Type of Practice/Specialty: _____

Health Care Provider: Phone Number: _____ Fax Number: _____

The above named-individual, who is a staff member of Academy District 20, has made a request to the district for an unpaid leave of absence and/or other accommodations due to COVID-19. We have requested that this individual provide us with medical documentation substantiating his/her request. Please complete this form and return to the staff member or fax to 719-234-1705.

- Does the staff member have an underlying medical condition, as defined by the Centers for Disease Control and Prevention (CDC), Colorado Department of Public Health and Environment (CDPHE), or El Paso County Public Health that increases their risk of serious illness from COVID-19?

  ☐Yes ☐No

- Please state the staff member's medical diagnosis and prognosis:

_____

_____

_____

Is their condition(s) temporary or permanent? _____

- Does this condition(s) restrict and/or create a limitation for the staff member to perform the essential functions of their position? If yes, how?

_____

_____

_____

- Please provide any recommendations for possible reasonable accommodations for the staff member in response to COVID-19:

_____

_____

_____

- If a leave of absence is recommended for the staff member, what are the anticipated dates for their leave of absence?

_____ _____

Start Date End Date

Health Care Provider's Signature: _____

Date: _____