Department of Corrections
WASHINGTON STATE

HIGH-RISK EMPLOYEE ACCOMMODATION REQUEST

Employee name	Personnel ID number	Facility/Office

I am an individual who is:

- ☐ Age 65+
- ☐ At increased risk of severe illness from COVID-19 as defined by the Centers for Disease Control and Prevention (CDC).
- ☐ Might be at increased risk of severe illness from COVID-19 as defined by the CDC.

  Please refer to the "at increased risk" and "might be at increased risk" categories listed on the CDC website.

I am requesting to:

- ☐ Work at an alternate location. Identify if you have a suggested location:

  _____

  Human Resources/your supervisor will contact you to discuss options.

- ☐ Telework. *Human Resources/your Supervisor will contact you to discuss options.*

  Note: If requesting to telework part-time, you must submit DOC 03-407 Leave Request for any time not worked.

- ☐ Leave for which dates: _____ to _____.

  Work with your local Human Resources if you need assistance with leave options under *State or Federal law.*

- ☐ Receive documentation to provide to the Employment Security Department in order to apply for benefits.

I understand I must either work, telework, or use paid leave for a minimum of 8 hours per month to maintain my health care benefits. I am responsible to pay the employee portion of the premiums, even if 8 hours per month does not generate enough income to cover my portion of the premium. Any unpaid portion will go into arrears. When I return to work full time, the Department will work with me to set up a payment plan to collect the amount in arrears.

If you are not working or teleworking full-time, you must submit a manual leave request form using DOC 03-407 Leave Request located on iDOC or the DOC website. Leave requests may be submitted electronically via Outlook to Roster for Custody employees or your supervisor for Non-Custody employees. **Do not submit FFCRA leave requests using MyPortal.** Supervisors will forward your approved leave requests through your local facility process. Please work with your local timekeeper or Headquarters Payroll processor if you and/or your supervisor need assistance.

I affirm the foregoing is true and correct and understand that any misrepresentations provided for this request will be basis for potential disciplinary action.

Dated this _____ day of _____, 20__ at _____, Washington.

_____
Signature

The name of my treating health care provider is (if applicable): _____

Note: Except for individuals who fall in the "might be at increased risk" category, you will not be asked to request medical documentation from your health care provider.

For employees who might be at high risk
Because you have identified that your health condition might be an increased risk, you are required to provide verification from a health care provider. Ensure your health care provider completes the medical certification statement below and return it to your local Human Resources office.

Medical Certification: Completed by Health Care Provider

Your patient has identified that they might be at increased risk for suffering severe illness from COVID-19 and have subsequently requested a High-Risk Accommodation. Please provide your contact information, complete all relevant parts of this section, and sign the form.

Employee/patient name: _____

☐ The above patient is suffering from a medical condition that may cause severe illness and increased risk for their current workplace conditions due to COVID as outlined by the CDC.

☐ The above patient is recommended for a leave of absence, as identified above, to avoid the potential exposure to COVID-19 related to their workplace conditions.

What is the expected duration of the serious health condition?
Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can. Terms such as "unknown" or "indeterminate" may not be sufficient to determine paid leave eligibility.

Start date: _____ **End date:** _____

I declare under penalty of perjury that the information provided in this form is true and correct, that the patient's condition meets the definition of "serious health condition" [RCW 50A.05.010], and that I am a healthcare provider authorized to certify their condition [RCW 50A.05.010 ; WAC 192-500-090].

Health Care Provider signature: _____ Date: _____

Health Care Provider's name (print): _____

Business address: _____

Type of practice/medical specialty: _____

Telephone (_____) _____ Fax: (_____) _____

Email: _____

HUMAN RESOURCES USE ONLY

Employee name | Personnel ID number | Facility/Office

☐ Telework or alternate work location approved.

☐ Leave approved - Employee requested, or after telework/alternate location offered, employee prefers to take own leave.

☐ Essential employee and agency lacks full-time telework or alternate work arrangements. Employee may seek unemployment benefits if they do not want to take leave.

Comments:

Human Resources Manager/designee | Signature | Date

APPOINTING AUTHORITY USE ONLY

☐ Approved ☐ Denied

Comments:

Appointing Authority | Signature | Date

*Approvals are authorized as long as the Proclamation is extended by the Governor.

The contents of this document may be eligible for public disclosure. Social Security Numbers are considered confidential information and will be redacted in the event of such a request. This form is governed by Executive Order 16-01, RCW 42.56, and RCW 40.14.

Distribution: **ORIGINAL** - Employee Occupational Health Record
COPY - Employee, Appointing Authority
COPY Page 3 only - Headquarters Payroll Help Desk, Roster (for custody employees), Supervisor