Office of Civil Rights & Title IX

COVID-19 Based Modification Request Form

Employee Name ________________________ LSU E-mail___________________

Phone Number _________________________ LSU ID #_____________________

Department ___________________________ Job Title _____________________

Immediate Supervisor ___________________ Regular Work Hours____________

I am seeking to

___ Teach/work synchronously remotely from non-campus location
___ Teach/work synchronously but virtually from a campus facility (without students in the physical classroom)
___ Other (please specify accommodations/modifications sought)

____

____ I have been vaccinated for COVID ____ I have not been vaccinated for COVID

Rationale to support request for accommodations/modifications:

____

____

____

____

EMPLOYEE MUST ALSO HAVE HEALTHCARE PROVIDER COMPLETE THE MEDICAL PROVIDER'S CERTIFICATION, ATTACHED TO THIS FORM

EMPLOYEE SIGNATURE_________________________ Date___________________

Return all documents to:
LSU Office of Civil Rights and Title IX
Attn: Jennie Stewart, ADA Coordinator
118 Himes Hall
employeeacc@lsu.edu
(225) 578-4442 FAX

Office of Civil Rights & Title IX

COVID-19 Based Modification Request Form
Medical Provider Certification

Employee Name ____

Name and address of Healthcare Provider:

____

____

____

Phone Number: _________________ E-mail address: __________________

Further Accommodations/Modifications Recommended: (Please list and describe)

____

____

____

____

Rationale for recommending workplace accommodations/modifications due to COVID 19 risk:

____

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LSU mitigation protocols are available at LSU COVID Roadmap
https://www.lsu.edu/roadmap/index.php

Daily Symptom Checker

Personal Protective Equipment

(hand sanitizer and dispensers, sanitary wipes, disinfectant spray and dispensers, paper towels, disposable masks, nitrile gloves)

HEPA air filters in classrooms
Testing of unvaccinated students and employees

Is physical presence at the employee's job more risky than grocery store, place of worship or other public space the individual enters? Yes ____ No _____

If yes, please explain
____
____
____
____

Has employee been vaccinated against COVID? ___ yes ___ no

If not, is the employee medically advised not to receive vaccine?
___ yes ___ no

Additional information not otherwise addressed in this form
____
____
____
____
____
____
____

Physician Signature: ____________________________ Date: ___________

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