

The American University in Cairo
COVID-19 Related Reasonable Accommodation Request Form

To Faculty and Staff:

Please refer to AUC’s Guidelines for Requesting Accommodations for COVID-19 Related Medical Reasons in completing this form. Faculty or staff whose age or health condition fall within one of the CDC High Risk conditions noted below may seek a workplace adjustment. This form will not be placed in your personnel file.

| | | | |
|---------------|--|----------------------|--|
| Name | | Email | |
| Date of Birth | | Work Phone No. | |
| Job Title | | Cell Phone No. | |
| Department | | Dean/Supervisor Name | |
| School | | Phone No. | |

(Please note that while your dean or supervisor will be involved in the process, information about your medical condition, including medical documentation, will not be shared unless authorized by you.)

People who are 65+ and have one or more of these following conditions may be at increased risk for severe illness from Covid-19. Please refer to CDC website @ <https://www.cdc.gov/> for more information.

| | |
|---|--|
| Active cancer | |
| Receiving immunosuppressive medications | |
| Receiving corticosteroids > 10 mg/day | |
| Severe obesity (body mass index [BMI] of 40 or higher) | |
| Uncontrolled diabetes | |
| Chronic kidney disease undergoing dialysis | |
| Chronic liver disease | |
| Other conditions not listed here but listed by the CDC or the MoHP of Egypt | |

What is the underlying condition for which you are requesting an accommodation and describe how the condition(s) affects performance of the essential function(s) of your job?

Is your condition temporary, permanent, or unknown? Please explain.

This is to acknowledge that I am requesting a reasonable accommodation for my duties and responsibilities at the university. I agree to fully cooperate with AUC Medical Clinic and the Provost or the SAVP of Human Resources in responding to my request, including providing the appropriate and additional medical documentation, if needed. I verify that the above information is complete and accurate to the best of my knowledge.

I also hereby authorize the release of medical information completed by my health care provider to AUC for the purpose of determining the availability of reasonable workplace accommodations. I further authorize AUC to seek clarification of this documentation, if necessary, by contacting my physician/health care provider noted on the Medical Information Form.

Name of Employee and signature

The American University in Cairo
Medical Information Form – To be Completed by the Health Care Provider

To Physician or Health Care Provider:

Faculty or staff whose age or health condition falls within one of the CDC or the MoPH's High Risk Categories may seek a workplace adjustment through a request for reasonable accommodation. To initiate a request for reasonable accommodations, employees must provide current documentation of an underlying medical condition that may warrant such reasonable accommodations by the university. As the employee's physician or healthcare provider, you are asked to fully complete this form. Additional information can be attached if necessary.

Does your patient currently have one or more of the following conditions?

| | |
|---|--|
| Active cancer | |
| Receiving immunosuppressive medications | |
| Receiving corticosteroids > 10 mg/day | |
| Severe obesity (body mass index [BMI] of 40 or higher) | |
| Uncontrolled diabetes | |
| Chronic kidney disease undergoing dialysis | |
| Chronic liver disease | |
| Other conditions not listed here but listed by the CDC or the MoHP of Egypt | |

Please describe the nature and severity of your patient's medical condition, including relevant medical facts related to the condition (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment).

Health Care Provider's Name/Practice:

Signature of Health Care Provider

Phone:

Fax:

Date:

Stamp of Provider