Des Moines Public Schools

COVID-19 Medical Information Request Form

for Medical Providers of DMPS Employees

To Des Moines Public Schools Employees:

- Employees must (1) complete Section I below, (2) provide details about the essential functions of their job to their medical provider, and (3) have their medical provider complete Section II.
- The Employee's *physician* or *health care provider* must complete Section II of the Medical Information Request form.
- Return completed forms to: Employee Services (attn. Cathy McKay) via direct FAX or e-mail submission.
    - Fax: (515)242-8455
    - E-mail: catherine.mckay@dmschools.org.

To Physician or Health Care Provider:

- To initiate a request for reasonable accommodations, employees must provide current documentation of a disability. As the employee's physician or healthcare provider, you are asked to fully complete all requests for information in Section II of this form. Additional information can be attached if necessary. Note: Federal and state law define a disability as a physical or mental impairment that substantially limits one or more major life activities, an individual having a record of such an impairment, or an individual being regarded as having such an impairment.
- To complete this form (see attached, page 2, Section II), you should consider the employee's job functions and other information relevant to the employee's job at Des Moines Public Schools. If this information has not been provided, please contact the employee and let him or her know you cannot complete this form without that information.
- The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. Thank you for your assistance.

Section I (To be Completed by Employee):

Name	Employee ID#	Job Title
Building/Department	Supervisor	

Release of Information:

I hereby authorize the release of the following information to Des Moines Public Schools for the purpose of determining the availability of reasonable workplace accommodations. I further authorize Des Moines Public Schools to seek clarification of this documentation, if necessary, by contacting my physician or health care provider.

I understand I may not be provided with the specific accommodation that I have requested.

I verify the information provided is complete and accurate to the best of my knowledge.

Employee Signature	Date

Section II (To be Completed by Physician or Health Care Provider):

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DMPS Employee Name

1. **What is the underlying condition for which the employee is requesting the accommodation?**

☐ Serious heart condition	☐ Chronic lung disease/damage	☐ Diabetes	☐ Cancer
☐ Pulmonary thrombosis	☐ Moderate to severe asthma	☐ Liver disease	☐ COPD
☐ Immunocompromised	☐ Hypertension or high blood pressure	☐ Pregnancy	☐ Smoking
☐ Neurologic condition	☐ Chronic kidney disease, undergoing dialysis	☐ Cystic fibrosis	☐ Thalassemia
☐ Cerebrovascular disease	☐ Severe obesity (BMI $\geq$40)	☐ Sickle cell disease	
☐ Other (please list): ______________________			

2. **Has as the employee been vaccinated for COVID-19?** ☐ Yes ☐ No

3. **Is the employee able to work in an in-person environment with accommodations?** ☐ Yes ☐ No

4. **If the employee is able to work in-person with accommodations, please identify accommodations that could enable the employee to perform their job duties.**

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______________________________ Duration: ______________
____
______________________________ Duration: ______________

5. **If the employee is unable to work in-person with accommodations, please identify accommodation that could enable the employee to perform their job duties.**

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______________________________ Duration: ______________
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______________________________ Duration: ______________

Thank you for your assistance in providing this information so that we may assess the employee's request. Please sign below.

Signature of Physician or Health Care Provider	Date
Provider Name (printed)	Telephone #
Name of Practice	Fax #
Address of Practice	Email Address