Ballard Spahr LLP

Medical Inquiry RE COVID-19 Request For Leave Or Reassignment

Employee name: _____

Request by employee for leave/reassignment: _____

Instructions to Health Care Professional Completing This Form:

The employee identified above has requested leave or reassignment from existing job duties on the basis that the employee or a family member is at risk due to COVID-19. We need additional information in order to evaluate that request.

Please do not provide any information about the employee's medical condition (or that of their family member) beyond what is necessary to respond to the questions below.

If you determine that the employee has a medical condition that makes them unable to perform one or more of the essential functions of their position in light of the COVID-19 pandemic, or that it would pose a direct threat to the employee or others to do so, please complete the corresponding questions to determine what accommodation, if any, is needed. Please do not provide information relating to any other medical conditions.

I have reviewed the job description for this employee. He/she: [check all that apply]

☐ is able to perform all essential functions of their position without posing a direct threat to themselves or others

☐ is able to perform the essential functions of his/her position with the following restrictions (describe below and complete the attached medical certification for accommodations):

_____

_____

☐ is unable to perform one or more essential functions of the position and should be placed on a leave of absence (complete the attached certifications of health care provider for employee's serious health condition and medical certification for accommodations)

☐ is unable to perform one or more essential functions of the position because of the need to care for a family member with a serious health condition (complete attached certification of health care provider for a family member's serious health condition)

☐ needs to be reassigned to different work based on a medical condition of the employee or their family member: (describe below and complete the attached medical certification for accommodations)

_____

_____

☐ is pregnant and needs to be placed on leave as a result of pregnancy-related conditions

Signature of Health Care Provider (sign and print name):		**Date**:
Type of Practice:	**Practice Address:**	**Phone Number (with area code):**

Please Note: 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.