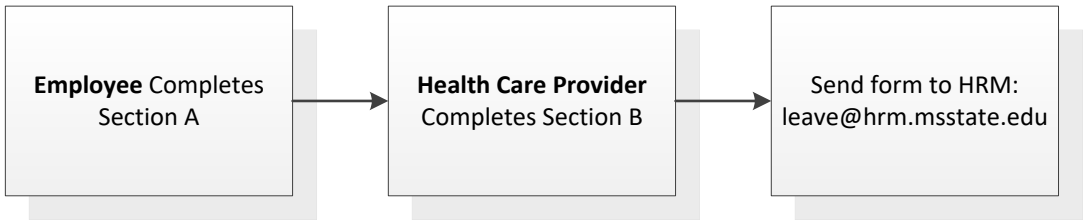
MISSISSIPPI STATE UNIVERSITY

Medical Documentation (COVID-19)

Instructions:



SECTION A: To be completed by Employee

Name:_____

Job Title: _____

Essential job functions:_____

_____

_____

_____

Job Description attached: _____ Yes ____ No

Employee signature _____Date_____

SECTION B: To be completed by Health Care Provider

The above-named patient has requested an accommodation to due to high-risk for severe illness from COVID-19. Please see this link for a list of categories under the CDC Guidelines: https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-at-higher-risk.html

MEDICAL FACTS

1. Approximate date condition commenced: _____

Probable duration of condition: _____

Date(s) you treated the patient for condition:

_____

2. Describe other relevant medical facts, if any, related to the condition for which the employee seeks an accommodation (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

_____

_____

_____

3. Do you recommend that the employee Telework based on the above information?

_____ Yes _____ No

Health Care Provider's name and business address:

_____

_____

Telephone: _____

Fax:_____

_____ _____

Signature of Health Care Provider Date

Send this form to HRM:
leave@hrm.msstate.edu