APSB Face Covering Accommodation Request Form- Employees

Employee Name		Employee ID	
School/Location & Position		Supervisor	

Face covering is mandated at APSB facilities. Request for accommodations that do NOT comply with this mandate will only be approved with the strictest of guidelines to ensure safety of others around the employee not wearing a face covering.

REQUESTED/ SUGGESTED ACCOMMODATION

Please describe the accommodations you believe are needed to enable you to perform the essential functions of this job. Check one of the following:

_____ Face covering accommodation (See statement below.)

The following are **mandatory requirements in lieu of a face covering:**

- Face shield and bandana/gaitor around neck.
- Maintaining proper distance of at least 6 ft. from all employees/ students in work/ school setting.
- Avoiding centrally used location, such as faculty work room.

_____ Also include any other accommodations that you are requesting at this time: (Other forms of face covering or other accommodations to be described here.) _____

_____

_____

MUST BE COMPLETED AND SIGNED BY PHYSICIAN'S OFFICE

NATURE OF THE QUALIFYING DISABILITY Please describe **specifically** the nature, extent, and duration of your patient's disability.

PHYSICIAN CONTACT INFORMATION Please provide name, address, telephone, and fax numbers. The physician may receive a letter/fax from us requesting additional information on your impairment/disability and recommendations for accommodations.

Physician name_____ Telephone number _____

Address _____ Fax number _____

Physician signature _____

Supervisor Signature	Date
HR Director Signature _____ Approve _____ Deny	Date
Superintendent Signature _____ Approve _____ Deny	Date

I authorize the release of necessary confidential medical information regarding my disability to relevant supervisors as deemed necessary by Human Resources. I also attest to the face that a copy of the position description has been given to me for review and reference.

By signing this form and not wearing a proper face covering, I acknowledge that I am at an increased risk of contractive COVID-19 and infecting others.

Employee signature _____ **Date** _____

Failure to follow these accommodation agreements may result in loss of permission to access campus and other APSB facilities.

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