



COVID-19 Medical Information Request Form

for Medical Providers of Jackson Public School District Faculty and Staff

To JPS Faculty and Staff:

- The Medical Information Request form is to be completed by the employee's physician or health care provider.
- Employees are to complete Section I below, provide details about the essential functions of their job to their medical provider and have the medical provider complete Section II.
- Completed forms are to be returned to: JPS via direct submission, or faxed to: (601) 352-4679 For questions, please call (601) 960-8745.

Section I: To be completed by faculty and staff:

Name	Job Title	School
Department	Supervisor	

Release of Information

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

Signature	Date
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Section II: To be completed by the physician or health care

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 sections 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 2), you should consider the employee's job functions and other information relevant to the employee's job at Jackson Public School District. 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.



Page 2, Section 2 Patient's Name _____

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

- Serious heart condition Chronic lung disease/moderate to severe asthma Diabetes
- Severe obesity (BMI ≥40) Chronic kidney disease undergoing dialysis Immunocompromised
- Liver disease Other _____

(Please specify)

2. Are you recommending remote work as an accommodation?

- Yes No

If so, what is the recommended duration for the accommodation?

3. If not recommending remote work, please identify accommodations that could enable the employee to perform his or her job duties.

• _____

_____ Duration _____

• _____

_____ 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 and Location of Practice