



**REQUEST FOR TEMPORARY WORK ADJUSTMENT RELATED TO COVID-19**

During the COVID-19 pandemic, the State of Colorado issued executive and public health orders that allow for employees that meet certain conditions to obtain work adjustments. Employees who are deemed by the State of Colorado to be “Vulnerable Individuals” (see criteria below), reside with or are caring for “Vulnerable Individuals,” or are facing child care needs because of COVID-19 should complete this form if you wish to request temporary work adjustments. Please know that, upon review, additional medical information may be requested if necessary. Completing this form does not guarantee that the temporary work adjustment will be approved.

**Employee Information**

Name: \_\_\_\_\_ Employee ID # (9 digits): \_\_\_\_\_  
 Email Address: \_\_\_\_\_ Home/Cell Phone: \_\_\_\_\_  
 Department: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Position: \_\_\_\_\_ Supervisor: \_\_\_\_\_  
 I currently work onsite or am being asked to return to work onsite. Yes \_\_\_ No \_\_\_

**Vulnerable Individual Criteria**

The State of Colorado’s public health orders currently state that a Vulnerable Individual, also known as an individual “at risk of severe illness from COVID-19,” is defined as an individual who:

- is 65 years and older;
- has chronic lung disease or moderate to severe asthma;
- has serious heart conditions;
- is immunocompromised;
- is pregnant; and/or
- is determined to be high risk by a licensed health care provider.

**Employee Certification**

**I hereby certify:**

- I meet the 65 years and older Vulnerable Individual criteria.
- I meet one or more of the other Vulnerable Individual criteria as defined above. Health Care Provider Certification required.
- I live with or am caring for \_\_\_\_\_, who is a Vulnerable Individual, and I am unable to adjust my living situation or my caretaking responsibilities to avoid close contact with them. Employee is required to submit Health Care Provider Certification. Additional information may be requested.
- I have dependent child(ren), \_\_\_\_\_:

Name of child(ren) and relationship to child(ren)

- \*whose school, place of care or child care provider, \_\_\_\_\_

Name of school, place of care or child care provider

is unavailable for reasons related to COVID-19 or

- who are learning remotely or
- are not with a child care provider for reasons related to COVID-19.

\*Note: you may be eligible for expanded Family Medical Leave created by the Families First Coronavirus Response Act (FFCRA). See <http://hrs.colostate.edu/benefits/timeoff-fap-fml.html>. Contact HR to obtain more information.

**I am requesting the following temporary work adjustment:**

- Use the following leave options, from \_\_\_\_\_ to \_\_\_\_\_.  
 Annual Leave    Sick Leave    Unpaid Leave
- Work remotely from \_\_\_\_\_ to \_\_\_\_\_.
- Other (including a flexible or modified schedule, a temporary assignment, etc.): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Employee Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Upon completion, please return the form to the Office of Equal Opportunity at [oeo@colostate.edu](mailto:oeo@colostate.edu).**

**Health Care Provider Certification (required for a vulnerable individual)**

I hereby certify that the above-referenced individual meets one or more of the State of Colorado's criteria for a Vulnerable Individual.

**Health Care Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Health Care Provider Name:** \_\_\_\_\_

**Office of Equal Opportunity**

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Email: [oeo@colostate.edu](mailto:oeo@colostate.edu) | [oeo.colostate.edu](http://oeo.colostate.edu)

**Human Resources**

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