DIXIE STATE UNIVERSITY™
ST. GEORGE, UTAH

REQUEST FOR TEMPORARY WORK ADJUSTMENT RELATED TO COVID-19

Under the direction of the University President and his Cabinet, the University is currently allowing employees who are concerned about returning to onsite work because they are a high-risk individual, live with a high-risk individual, or have another COVID-related reason to apply for and be considered for a **Temporary Work Adjustment (TWA)** by completing this form.

The fully signed form should be returned to the Executive Director of Human Resources. HR will confirm to the supervisor that the employee is eligible to receive a Temporary Work Adjustment (TWA). Completing this form is no guarantee that the temporary work adjustment will be approved. Temporary work adjustments must be analyzed by the department and may be approved, based on the needs and abilities of the department, using fair and objective criteria (with oversight from the division's Vice President).

Employee Information

Name: _____ Employee ID # _____

Email Address: _____ Home/Cell Phone: _____

Department: _____ Work Phone: _____

Supervisor: _____ Position: _____

High-Risk Individual – CDC Criteria

The CDC has warned that older adults (age 65 or older) and people of any age who have one of the following serious underlying medical conditions might be at higher risk for severe illness from COVID-19:

- Asthma: moderate to severe
- Cancer
- Cerebrovascular Disease
- Chronic Kidney Disease
- COPD
- Cystic Fibrosis
- Down Syndrome
- Heart conditions such as heart failure, coronary artery disease, cardiomyopathies
- Hypertension or high blood pressure
- Immunocompromised due to organ, blood, or bone marrow transplant, immune deficiencies, HIV, use of corticosteroids, or other immune weakening medicines
- Liver Disease
- Neurologic Conditions, such as dementia
- Obesity (BMI > 29)
- Pregnancy
- Pulmonary Fibrosis
- Sickle Cell Disease
- Smoking
- Thalassemia
- Type I or II Diabetes

Employee Certification

I hereby certify:

☐ I meet one or more of the CDC's criteria to be considered an individual at high risk (set forth above).*

☐ I live with _____, who is an individual who meets one or more of the high risk criteria above and I am unable to adjust my living situation to avoid close contact with them.*

☐ I am age sixty-five (65) or older or live with an individual who is age sixty-five (65) or older.

☐ I have a personal reason (not related to the CDC high-risk criteria) that I would like considered for a TWA. I understand that details of my request will be shared with my supervisor and dean or VP, and that approval of the requested TWA is at the discretion of the supervisor and dean/VP. The reason for my request is: *(please describe in detail)*

_____

_____

I am requesting the following TWA:

☐ Working remotely from _____ to _____. (not to exceed 16 weeks or one academic semester)

☐ Other: _____

Employee Signature: _____ Date: _____

*See reverse for Health Care Provider Certification, if required.

Completed forms may be faxed to (435) 656-4001 (Attn: Travis Rosenberg) or emailed to HR director at: travis.rosenberg@dixie.edu

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* Health Care Provider Certification *(Required for an Individual who is Under 65 and at High Risk for Severe Illness from COVID-19)*

I hereby certify that the above-referenced individual meets one or more of the High-Risk Individual Criteria outlined above.

Health Care Provider Signature: _____ Date: _____

Health Care Provider Name: _____

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