BAYONNE BOARD OF EDUCATION
ADMINISTRATION BUILDING
669 Avenue A
Bayonne, NJ 07002

Kenneth Kopacz
ASSISTANT SUPERINTENDENT

Tel: (201)-858-5847
Fax: (201)-339-7431

FORM A

(you must also submit a WH-380 Certification of Health Care Provider – Employee)

Request for Reasonable Accommodation due to "Particularly Vulnerable to COVID-19."

Employee to Complete:

Employee Name: _____

Job Title: _____

Work Schedule (days and times): _____

Work Site(s): _____

Physician to Complete:

Physician's Name: _____

Office Address: _____

_____

Telephone: _____

Facsimile: _____

Email: _____

Information Concerning Employee (*please attach additional pages, as necessary*)**:**

1. Medical Condition(s) that causes Employee to be particularly vulnerable to COVID-19:

   _____

   _____

2. For each condition, please explain **with a reasonable degree of medical certainty** *(use multiple forms, as needed)*:

   a. Approximate date when condition commenced.

   b. The anticipated duration of the condition (if unknown, please advise the condition will persist through June 30, 2021).

   c. How condition causes the Employee to be particularly vulnerable to COVID-19.

   d. Whether there are workplace accommodations that would decrease the risk for the Employee to perform the essential functions of his/her position (please refer to the Employee's job description).

   e. For any workplace accommodations you identified above, please explain how they would prevent the Employee from being particularly vulnerable to COVID-19.

   f. Under what circumstances would the Employee no longer be deemed particularly vulnerable to COVID-19?

3. Next treatment/examination date of Employee. _____

Doctor's Signature: _____

Date: _____

(see next page for medical authorization)

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EMPLOYEE AUTHORIZATION TO RELEASE/DISCLOSE INFORMATION TO THE BAYONNE BOARD OF EDUCATION.

I, _____, authorize the Employee Health Department and the Office of the Superintendent of the Bayonne School District to speak with and disclose information and records to my doctor concerning the information contained herein, for purposes of seeking clarification of the information that has been provided. I similarly authorize my doctor, named above, to speak with and disclose information and records to the _____.

This authorization shall expire on June 30, 2021.