COVID-19 Work Arrangement Request

3-20

Instructions for Employees or Household Members Directed By a Doctor to Self-Quarantine Due to an Underlying Medical Condition:

Part 1 - To be fully completed by Employee. Please do not share medical details on this form. Submit to COVID19-WPAT@Verizon.com or submit via secure fax to 1-908-559-7099.

1. Sign the Medical Authorization (Part 2) and submit it to the Workplace Accommodations Team.
2. Give the Medical Questionnaire (Part 3) and Medical Authorization (Part 2) to your Health Care Provider.

Employee Name:	**Employee ID** (available in Verizon e-Directory)
Employee work address, including city and state: **Employee Home /Cell phone Number:** **Personal Email:**	

Has a doctor directed self-quarantine due to an underlying medical condition for yourself or a household member?

YES_____ NO_____

Please identify the workplace arrangement that you are requesting.

If your doctor or your household member's doctor has suggested possible arrangements within the workplace please describe the proposed arrangements:

Describe how this arrangement will help you or your household member.

Indicate how long this arrangement will be required: _____

You are required to provide supporting material from a Health Care Provider (HCP) supporting this request. According to federal law regarding privacy of medical records, an HCP may require authorization prior to furnishing medical information to Verizon. It is your responsibility to work with the HCP in order to ensure that he/she provides your medical information to Verizon so that a decision can be made regarding your request.
Please sign the attached Medical Authorization Form (Part 2) so the Workplace Accommodations Team can contact your HCP regarding your request for accommodations, **if this request is for your own underlying medical condition.**
Initial to acknowledge you have read the above: _____

Employee Signature (or preparer's signature if verbal)	**Date**

SUPERVISOR INFORMATION	
Name (Last, First, MI)	
Office Phone Number	Office E-mail Address

For questions contact the Workplace Accommodations Team at **COVID19-WPAT@verizon.com.**

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entitles covered by GINA Title II from requesting or requiring genetic information of employees or their family members. In order 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 members' genetic tests, the fact that an individual or an individual's family member sought or received genetic Services, and the 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 received assistive reproductive services.

Employee Action if this request is for your own underlying medical condition:

Part 2 – Sign this Medical Authorization, and submit to the Workplace Accommodations Team at COVID19-WPAT@verizon.com or FAX to 1-908-559-7099. You can include any related medical records.

Additionally, in order to medically substantiate the request, you may be required to submit medical documents related to your request.

Employee Action for all requests:

Provide Part 3 to a health care provider and have the provider complete Part 3 of the Medical Questionnaire. You or the provider should EMAIL the completed Medical Questionnaire form to the Workplace Accommodations Team at COVID19-WPAT@verizon.com or FAX to 908-559-7099.

Verizon Workplace Accommodations Team
One Verizon Way
Basking Ridge, NJ 07920
EMAIL: COVID19-WPAT@verizon.com
FAX: 1--908-559-7099

Authorization to Disclose Information About Me

For purposes of administering my request for accommodation(s), I permit and authorize: any physician, other medical/treating practitioner, hospital, clinic or other medical-related facility/service (and any medical consultants or examiners that may be retained in connection with my request for workplace arrangements) to disclose to the Verizon Workplace Accommodations Team ("WPAT"), in its capacity as evaluator of my request for workplace arrangements, any and all information concerning my Workplace Arrangement request and medical care that is related to this request.

I understand that Sedgwick Claims Management Services ("Sedgwick") and Anthem Inc. ("Anthem Inc.") performs advisory services to WPAT to enable WPAT to determine if my request for workplace arrangements is medically substantiated. **For purposes of performing such advisory services,** I authorize any physician, other medical/treating practitioner, hospital, clinic or other medical-related facility/service (and any medical consultants or examiners that may be retained in connection with my request for workplace arrangements) to disclose to Sedgwick or Anthem, upon request, any and all information concerning my Workplace Arrangement request and medical care that is related to this request.

WPAT and/or Sedgwick and Anthem, in their respective capacities and for the purposes set forth above, are authorized to use any information relevant to my request for workplace arrangements that may be contained in any file maintained by Sedgwick or Anthem related to a claim made by me for Worker's Compensation benefits or for any group disability income benefits under a Verizon plan.

This form specifically grants my permission to disclose medical information, records, test results, and data on: medical care or surgery; psychiatric or psychological conditions; and alcohol or drug abuse (including any data protected by Federal Regulations 42 CFR Part 2 or other applicable laws) with the specific exception of psychotherapy notes.

Information concerning mental illness, HIV, AIDS, HIV related illnesses and sexually transmitted diseases or other serious communicable illnesses might be controlled by various laws and regulations. I consent to disclosure of such information, but only in accordance with laws and regulations as they apply to me. Information that may have been subject to privacy rules of the U.S. Department of Health and Human Services, once disclosed, may be subject to re-disclosure by the recipient and may no longer be covered by those rules.

I understand that I may revoke this authorization at any time by writing to both the Verizon Workplace Accommodations Team, One Verizon Way, Basking Ridge, NJ 07920 and Sedgwick, P.O. Box 14192, Lexington, KY, 40512-4192 (Fax: 1-859-264-4384), except to the extent that action has been taken in reliance on it by either party before such party's receipt of my revocation. If I do not, this authorization will be valid for 18 months from the date I sign this form or the duration of my request for workplace arrangements, whichever period is shorter. A photocopy of this authorization is as valid as the original form and I have a right to receive a copy upon request.

_____ _____
Printed Name of Employee **Employee ID or Enterprise:**

_____ _____
Signature of Employee: **Date:**

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Part 3 – Medical Questionnaire - To be completed by Health Care Provider

Employee Name:
Employee Identification:
WPA Case #:

Health Care Provider:
Your patient has indicated that you directed self-quarantine due to an underlying medical condition (Employee or the employee's household member) and provided a signed medical authorization. This form requests supporting information and documentation. Answer all questions to a reasonable degree of medical probability.

Send To:
Verizon Workplace Accommodations Team Secure fax: 908-559-7099 or email **COVID19-WPAT@verizon.com**

For questions contact:
Verizon Workplace Accommodations Team at **COVID19-WPAT@verizon.com**

1. Have you directed this employee to Self-Quarantine due to an underlying medical condition of the employee or employee's household member?

2. What is the underlying medical condition?

3. What is the expected duration of the employee's underlying condition?

4. What is the expected duration of the employee's need to Self-Quarantine due to this underlying condition?

5. If workplace arrangements are recommended state the start date and end date.

   Workplace Arrangement Start Date: _____ Workplace Arrangement End Date: _____

Telephone Number: _____ Physician/Provider Print Name: _____

Fax Number: _____ Physician/Provider Title/Specialty: _____

Email Address: _____ Physician/Provider Signature: _____

Date Completed: _____

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